

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5699

## CERTIFICATE OF DEATH

05656

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN 1b <b>2297 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>705 Sudbrook Rd., Pikesville 8, Md.</b>		d. STREET ADDRESS <b>o 3X - 21</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>G.</b>	Middle <b>C.</b>	Last <b>Atkinson</b>	4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>1958</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>WIDOWED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b>	8. DATE OF BIRTH <b>Sept. 5, 1878</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George C. Atkinson</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Roxroath</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-2143</b>	17. INFORMANT <b>Records of Victor Cullen Hospital</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X</b> DUE TO <b>Cardio-respiratory failure</b> INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO <b>7 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>1/30/52</b> , 19 <b>52</b> , to <b>5/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/14/58</b> , 19 <b>58</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Michael G. Zavis</b> ADDRESS (Street, city or town, state) <b>ADDRESS</b> DATE SIGNED <b>DATE SIGNED</b>					
PHYSICIAN'S NAME (Type) <b>Michael G. Zavis, M.D., Victor Cullen State Hospital, Cullen, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peters</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond &amp; Oregon Thurmont</b>		ADDRESS <b>1600</b>	24a. REC'D BY REGISTRAR <b>MAY 16 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Q. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## STATE OF HAWAII

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD LEE KELLY	50	M	HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	PLACE OF DEATH
1100 KAHANAMOKU	50	10:00 P.M.	HOSPITAL
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. RICHARD L. COOPER 1100 KAHANAMOKU	WILLIAM T. KELLY 1100 KAHANAMOKU		
NAME AND ADDRESS OF PERSON REPORTING	RELATIONSHIP TO DECEASED		
EDWARD LEE KELLY 1100 KAHANAMOKU	SPOUSE		
DATE OF DEATH	TIME OF DEATH	PLACES DECEASED	
NOVEMBER 20, 1968	10:00 P.M.	HOSPITAL	
NAME OF PERSON SIGNING	RELATIONSHIP TO DECEASED		
EDWARD LEE KELLY	SPOUSE		
DATE OF SIGNING	TIME OF SIGNING		
NOVEMBER 20, 1968	10:00 P.M.		

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05657

5700

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN lb <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TRA CALVIN BARRICK</b>		First	Middle
4. DATE OF DEATH <b>MAY 14 1958</b>		Month	Day Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/7/1885</b>		9. AGE (In years lost, birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTAINANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUNICIPALITY</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>WILLIAM BARRICK</b>	
14. MOTHER'S MAIDEN NAME <b>ADA KEENEY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MARSHALL SHAFFER, UNION BRIDGE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3</b> DUE TO <b>Meningitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Infection - in currency</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Union Bridge</b>		20f. (City or town) (County) (State) <b>Union Bridge MD</b>	
21. I certify that I attended the deceased from <b>4-28-1958</b> to <b>5-13-1958</b> that I last saw the deceased alive on <b>5-13-1958</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. H. Hegg</b>		ADDRESS (Street, city or town, state) <b>Union Bridge MD</b>	
PHYSICIAN'S NAME (Type) <b>T. H. HEGG MD</b>		DATE SIGNED <b>5-14-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>BETHEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DR Harbison Union Bridge Md</b>		ADDRESS <b>DR Harbison Sons Union Bridge Md</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>A. Harbison</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF STATE HISTORIC  
COMMISSION

RECEIVED  
MAY 19 1980  
LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5666

## CERTIFICATE OF DEATH

Reg. Dist. No.

05658

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>114 East Seventh Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>PAMELA</b>	Middle <b>LEE</b>	Last <b>Bell</b>	4. DATE OF DEATH <b>May 24 1958</b>	Month <b>May</b>	Day <b>24</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1958</b>	9. AGE (In years less than birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles C. Bell</b>				14. MOTHER'S MAIDEN NAME <b>Barbara A. DeGrange</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Charles C. Bell - Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Fetal atelectasis</b> DUE TO (b) <b>(Prematurity 30 weeks)</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 22, 1958</b> , to <b>May 24, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Bernard O. Thomas, Jr.</b> ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>May 24, 1958</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Bernard O. Thomas, Jr.</b>		Professional Building					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick,</b> (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 27 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Lebeduck</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF HENRY COUNTY ILLINOIS

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5701 CERTIFICATE OF DEATH

05659

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - New London</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>P.O. -- Mt. Airy- Route 1</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - New London</b>	
3. NAME OF DECEASED (Type or print) <b>William Henry Bell</b>		First <b>William</b>	Middle <b>Henry</b>
4. DATE OF DEATH <b>May 25th 1958</b>	Last <b>Bell</b>	Month <b>May</b>	Day <b>25</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <b>Oct. 16-1892</b>
9. AGE (In years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months <b>65</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. FATHER'S NAME <b>Cyrus Bell</b>	14. MOTHER'S MAIDEN NAME <b>Theresa Eaves</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>219-36-4037</b>	17. INFORMANT <b>John Bell - New London-Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lympho-sarcoma (generalized)</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>  200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b)  DUE TO  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 30, 1958</b> , to <b>May 25, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>May 27, 58</b>			
ACTUAL SIGNATURE <i>R. O. Thomas Jr.</i>	M.D.		
PHYSICIAN'S NAME (Type) <b>Dr. R. O. Thomas-Jr.</b>	Frederick - Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-28-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Union Chapel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Libertytown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline &amp; Son</i>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Rehm</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05660

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>*Henry*</b>		First <b>Ollie</b>	Middle <b>May</b>
4. DATE OF DEATH <b>Bowen</b>		Lost <b>May 12</b>	Month Day Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>New Market, Md.</b>
13. FATHER'S NAME <b>Charles E. Phebus</b>		14. MOTHER'S MAIDEN NAME <b>Mary Crummitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT None
		Address <b>J. William Bowen, Mt. Airy, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260x Diabetes mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day Year at work <input type="checkbox"/> at work <input type="checkbox"/>
20d. INJURY OCCURRED White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick, Md.</b>		(County) <b>Frederick Co.</b>	
		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>5/7</b> , 1958, to <b>5/12</b> , 1958, that I last saw the deceased alive on <b>5/12</b> , 1958, and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		ADDRESS (Street, city or town, state) <b>4 E Church St</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		DATE SIGNED <b>5/12/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Pleasant Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Monrovia, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mosemann</b>		ADDRESS <b>Damascus, Md.</b>	
		24. REC'D BY REGISTRAR DATE <b>MAY 15 '58</b>	
		25. REGISTRAR'S SIGNATURE <b>Albert Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use of the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/55



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Item 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

cur the certificate, write the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 13 2,3,7,11,13,14,15 File No 229 6-2-58 et Reg. Dist. No. 05661											
1. PLACE OF DEATH Items 8,9 & 16, Film G-230 a. COUNTY Frederick 6/16/58 MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pronwick			c. LENGTH OF STAY IN 16			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Forest			d. STREET ADDRESS 312 Shawnee		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Capt. Kenneth J. Brady	Middle	Last	4. DATE OF DEATH May 20	Month	Day	Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1919	9. AGE (In years from birth to death) 38 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisville, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jessie C. Brady						14. MOTHER'S MAIDEN NAME Virginia Kendall Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes			16. SOCIAL SECURITY NO. W.W. TT 401-09-0453			17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 861X Multiple fractures and injuries INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year 1:45 a.m. 5-20 58			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air			20f. (City or town) (County) (State) Rural Frederick Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>B. O. Thomas</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED May 20, 1958		
EXAMINER'S NAME (Type) Dr. B. O. Thomas			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE OF BURIAL, CREMATION, REMOVAL 5/21/58		22c. NAME OF CEMETERY OR Crematory L. P. PEARSON FUNERAL HOME		22d. LOCATION (City and County) ST. MATHEWS		(State) KY.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. O. Thomas</i>						ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR MAY 26 '58		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5668 CERTIFICATE OF DEATH

05662

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Since 6/39</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Unk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Headville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Maryland Odd Fellows Home</b>				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle	Last <b>BRENT</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>16,</b>	Year <b>1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>26 May 1863</b>	9. AGE (In years less birthday) <b>94</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Leesburg, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>James Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Osborn</b>				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Maryland Odd Fellows Home Records</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>May 16, 1958</b> , that I last saw the deceased alive on <b>May 15, 1958</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
ACTUAL SIGNATURE <i>Wm. M. Smith</i> Frederick, Maryland											
DATE SIGNED <b>5-17-58</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-20-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W. E. Etchison</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5669 CERTIFICATE OF DEATH

05663

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		a. STATE <b>Maryland</b>	b. COUNTY <b>Carroll</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hosp.</b>		d. STREET ADDRESS <b>Winfield</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LeRoy</b>	First <b>L</b>	Middle <b>E</b>	Last <b>Buckingham</b>	4. DATE OF DEATH <b>May 27, 1958</b>	Month Day Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-1887</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Nelson Reid Buckingham</b>		14. MOTHER'S MAIDEN NAME <b>Sarah A. Deckenbaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 146-18-5203</b>		17. INFORMANT <b>Mrs. Ray Brown,</b>	Address <b>Same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.0</b>		<b>Acute Pulmonary edema</b> <b>12 hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<b>Arteriosclerotic Heart Disease</b> <b>3 yrs +</b>			
DUE TO <b>420.0</b>					
DUE TO <b>Arteriosclerotic Heart Disease</b>					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/27, 1958</b> to <b>5/27, 1958</b> , that I last saw the deceased alive on <b>5/27, 1958</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>46 Church St</b> <b>Baltimore Md</b>			
ACTUAL SIGNATURE <b>Henry V Chase</b>		DATE SIGNED <b>5/27/58</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>					
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-30-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ebenezer</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ,</b>		ADDRESS <b>Winfield, Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Waltz</b>	



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write "Pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
FREDERICK MARYLAND		a. STATE Md.	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Brunswick		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS 8427 Pleasant Plain Ave	
First DONALD Middle A. CHALMERS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX MALE		4. DATE OF DEATH May 20 1958	
6. COLOR OR RACE WHITE		5. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH Oct 26, 1937 ?		8. AGE (In years last birthday) 20 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) PFC		10b. KIND OF BUSINESS OR INDUSTRY A4 Nat'l. Guard	
10c. BIRTHPLACE (State or foreign country) Md.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert E. Chalmers		14. MOTHER'S MAIDEN NAME Rita V. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes / Active		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Albert E. Chalmers		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE EXTREME INJURIES DUE TO "60X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRPLANES Collided in AIR	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 45 5-20 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AIR 20f. (City or town) (County) (State) RURAL FREDERICK MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B.C. Thomas		DATE SIGNED 5-20-58	
EXAMINER'S NAME (Type) B.C. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/58	
22c. NAME OF CEMETERY OR CREMATORIAL Moreland's Mem. Park		22d. LOCATION (City, town, or county) Baltimore Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers. Wash, D.C.		24a. REC'D BY REGISTRAR MAY 23 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Albert couch	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05665

Reg. Dist. No.

5670

1. PLACE OF DEATH  
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN TB

Years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First  
EVELYN

Middle  
MARIE

Last  
CLARK

4. DATE  
OF  
DEATH

Month  
May

Day  
30, 1958  
Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

September 16, 1913

9. AGE (In years  
from birthday)  
44 yrs.

IF UNDER 1YEAR	IF UNDER 24 HRS.
Months	Days
Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles W. Stitely

14. MOTHER'S MAIDEN NAME

Grace Grinder

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unk

17. INFORMANT

Mr. Lewis Clark, Jr.— Same as Item #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a)

Massive Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH  
**1½ Hours**

231X

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m. 19

20d. INJURY OCCURRED  
While at work  Not white at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

*B. O. Thomas*

DATE SIGNED

EXAMINER'S  
NAME (Type) Dr. B. O. Thomas

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

5/31/58

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

June 2, 1958

22c. NAME OF CEMETERY OR CREMATORIUM

Mount Hope Cemetery

22d. LOCATION (City, town, or county)

Woodsboro,

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

M. R. Etchison & Son, Frederick, Maryland

24a. REC'D BY REGISTRAR

JUN 2 '58

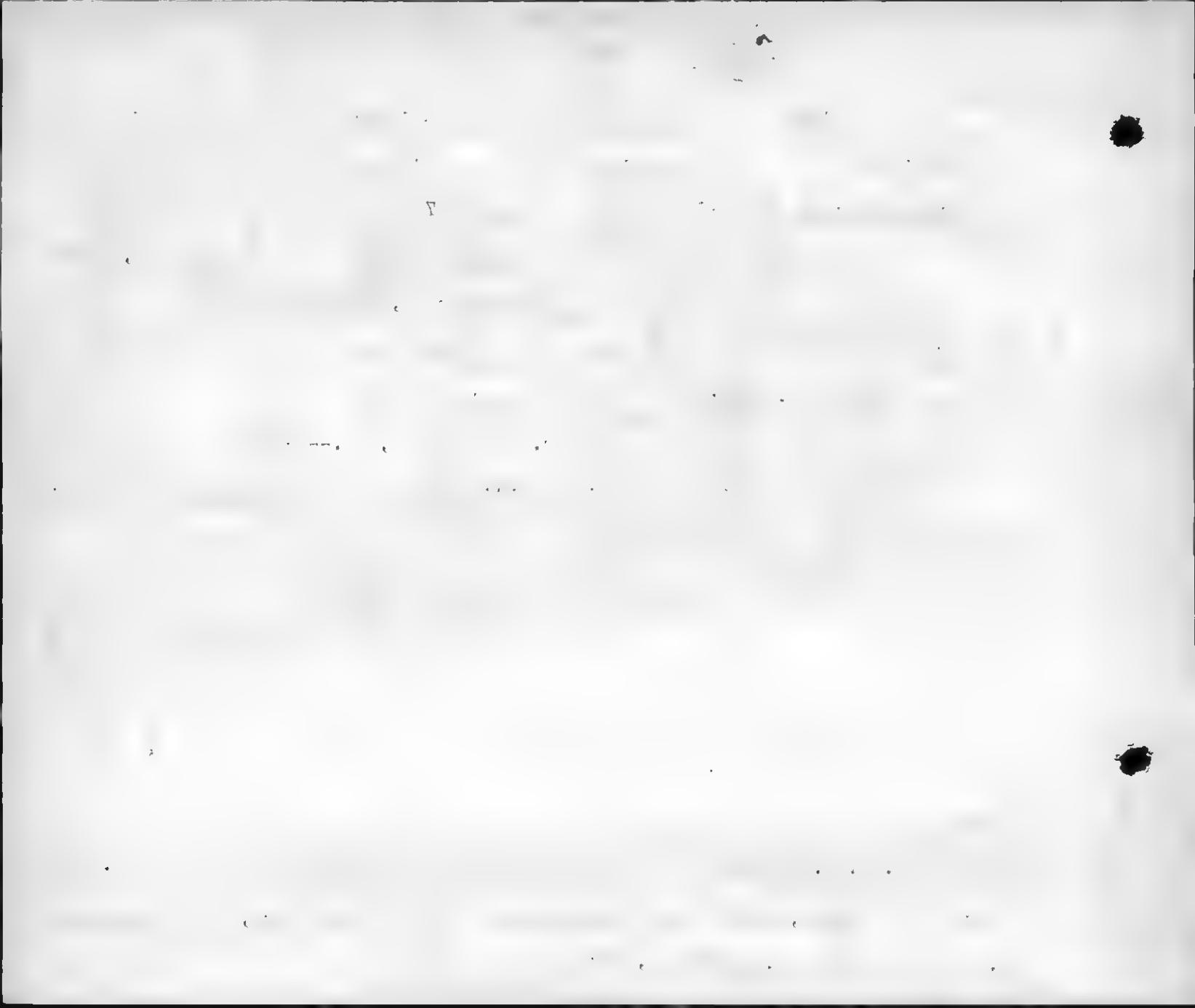
DATE

24b. REGISTRAR'S SIGNATURE

*John E. Etchison*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transtil permit. File pages 1 and 2 with the registrar prior to burial or removal.

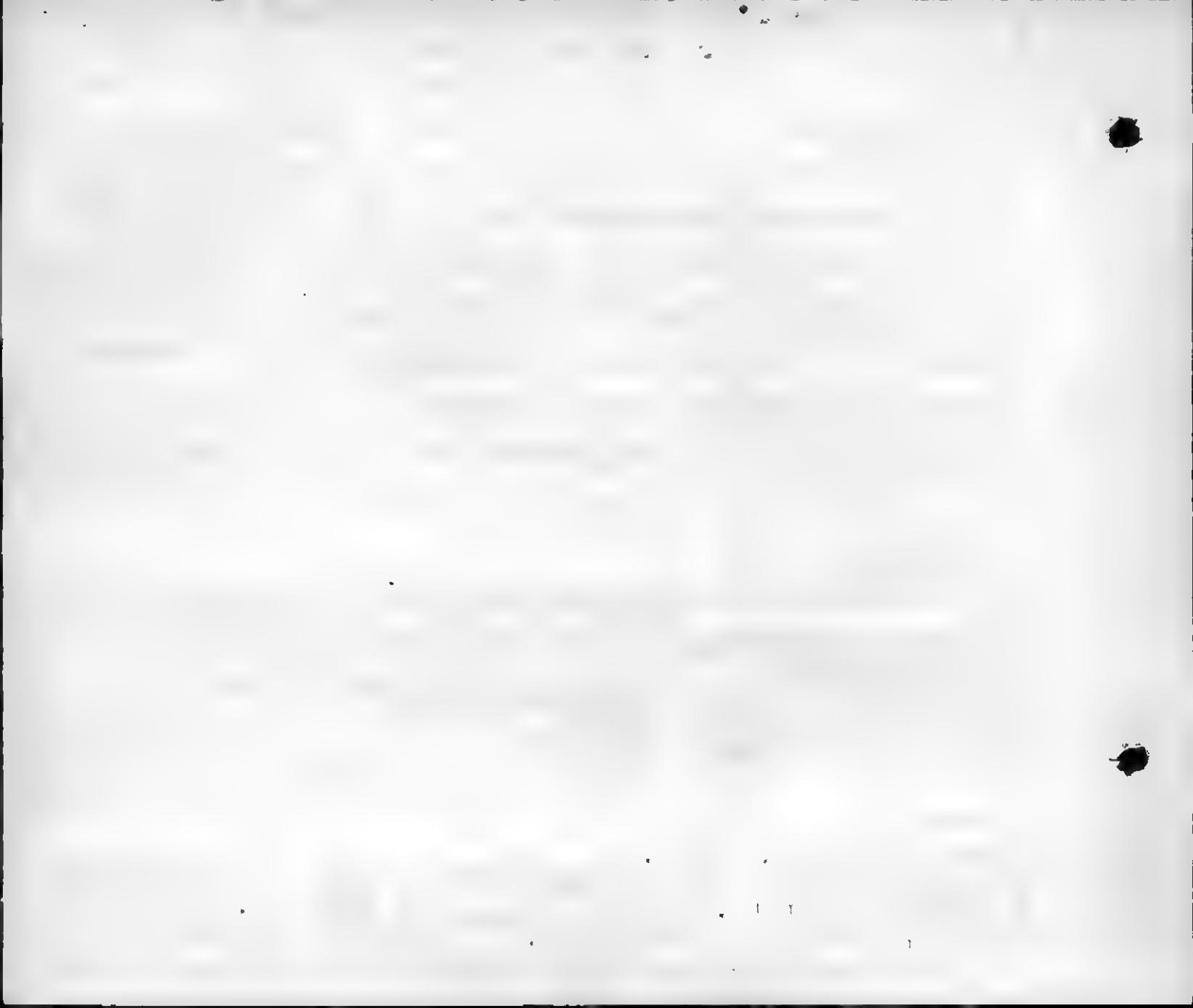
VS. ATME(S) 5/31/58  
SM 9/55



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 05666		
5671 CERTIFICATE OF DEATH												
<b>PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> b. STATE <b>Pennsylvania</b> <b>b. COUNTY Westmoreland</b>							
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>RURAL</b>		<b>c. LENGTH OF STAY IN lb</b>			<b>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>Derry</b>		<b>d. STREET ADDRESS</b> <b>228 3rd Avenue</b>			<b>d. STREET ADDRESS</b> <b>75x-3</b>		
<b>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION</b> <b>WRAH Ward 200 Fort Detrick, Md.</b>		<b>e. IS RESIDENCE ON A FARM?</b> <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>										
<b>3. NAME OF DECEASED (Type or print)</b> <b>Mary</b>		<b>First</b> <b>Ellen</b>		<b>Middle</b> <b>Clark</b>		<b>4. DATE OF DEATH</b> <b>May 7 1958</b>		<b>Month</b> <b>Day</b> <b>Year</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Cau.</b>		<b>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>8. DATE OF BIRTH</b> <b>October 18, 1873</b>		<b>9. AGE (In years lost birthday)</b> <b>84 yr.</b>		<b>10. IF UNDER 1 YEAR</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>		
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Pennsylvania</b>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>						
<b>13. FATHER'S NAME</b> <b>Michael L. Mowry</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Richardson</b>								
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Colonel Alice B. Clark</b>		<b>Address</b> <b>Fort Detrick, Md.</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hours</b>		
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Heart Failure</b> <b>420.0</b> <b>DUE TO</b> <i>Arteriosclerotic Heart Disease</i>												
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(b)</b> <i>Severe cerebral arteriosclerosis with cerebral vascular accidents, multiple</i> <b>DUE TO</b> <i>Cerebral vascular accidents, multiple</i> <b>(c)</b> <i>Cerebral arteriosclerosis</i>										<b>6 weeks</b> <b>10-15 years</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>DST</b>		<b>(County)</b> <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b>				
<b>21. I certify that I attended the deceased from</b> <i>28 April, 1958</i> , to <i>7 May, 1958</i> , <b>that I last saw the deceased alive on</b> <i>7 May, 1958</i> , <b>and that death occurred at</b> <i>7:25 P.M.</i> , <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <i>Edwin L. Overholst</i> <b>M.D.</b>												
<b>PHYSICIAN'S NAME (Type)</b> <b>EDWIN L. OVERHOLT.</b>												
<b>22a. BURIAL, CREMATION, REMOVAL (specify)</b> <b>REMOVAL</b>		<b>22b. DATE THEREOF</b> <b>MAY 8, 1958.</b>		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <b>FREDERICK MD.</b>		<b>22d. LOCATION (City, town, or county)</b> <b>DERRY Penn.</b>		<b>(State)</b>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>DAILEY'S FUNERAL HOME</b>		<b>ADDRESS</b> <b>FREDERICK MD.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 12 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>D. Miller</b>						



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05667

5704

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>		c. LENGTH OF STAY IN 1b <b>81 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>		d. STREET ADDRESS <b>Route # 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>OTHO</b>	Last <b>CLINE</b>	4. DATE OF DEATH Month <b>May</b>	Month <b>7</b>	Day <b>1958</b>	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1876</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Issiah Cline</b>				14. MOTHER'S MAIDEN NAME <b>Manzella Shank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>219-36-4404</b>		17. INFORMANT <b>Mrs. Viola Cline, Myersville, Md., Rt. # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio - Neural - Vascular Disease</b> DUE TO <b>Advanced arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <b>Advanced arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 7, 1958</b> , to <b>May 7, 1958</b> , that I last saw the deceased alive on <b>May 7, 1958</b> , and that death occurred at <b>Myersville, Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Myersville, Md.</b>							
ACTUAL SIGNATURE <b>John F. Cline</b>							
PHYSICIAN'S NAME (Type) <b>J. F. Cline, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Paul's Lutheran</b>		22d. LOCATION (City, town, or county) <b>Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Billie</b>		ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>May 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Asst. Health</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: If this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

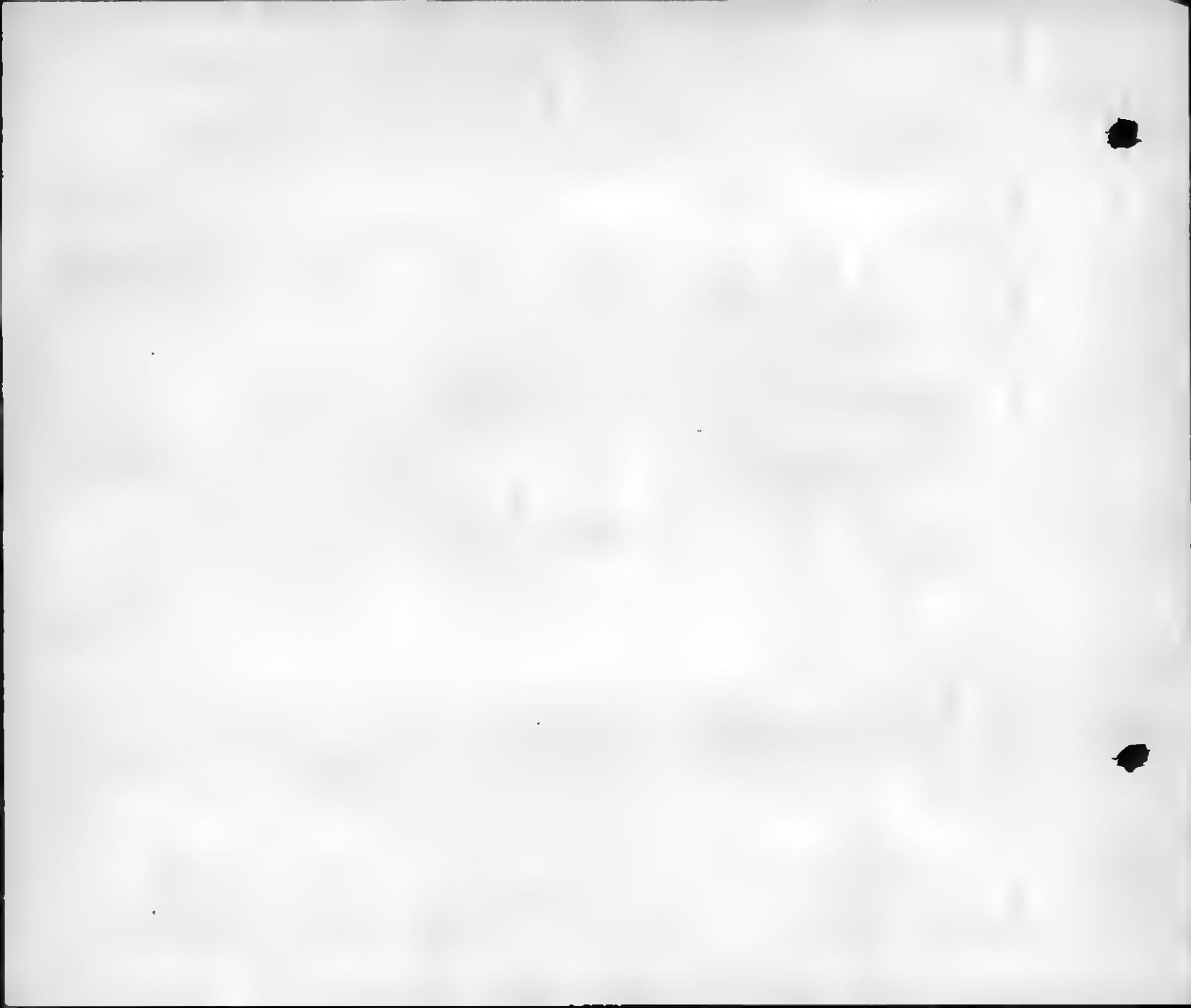
## 5795 CERTIFICATE OF DEATH

Reg. Dist. No.

05668

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3. STREET ADDRESS <b>/</b>		d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ralph</b>		First	Middle <b>Melvin</b>	Last <b>Crone</b>	4. DATE OF DEATH Month <b>5</b>	Day <b>6</b>	Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/4/1898</b>	9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>gas company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert H. Crone</b>		14. MOTHER'S MAIDEN NAME <b>May V. Stone</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-10-5178</b>		17. INFORMANT <b>Mrs. Maude Crone, Jefferson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<b>Caronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <b>Advanced Caronary disease</b>		<b>Advanced Caronary disease</b>		8 mo			
(c) DUE TO <b>Previous myocardial infarct</b>		<b>Previous myocardial infarct</b>		1 M			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1958</b> to <b>May 6, 1958</b> , that I last saw the deceased alive on <b>May 5, 1958</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. J. Bruce M.D.</b>				ADDRESS (Street, city or town, state) <b>Jefferson</b>		DATE SIGNED <b>5/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/9/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05669

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

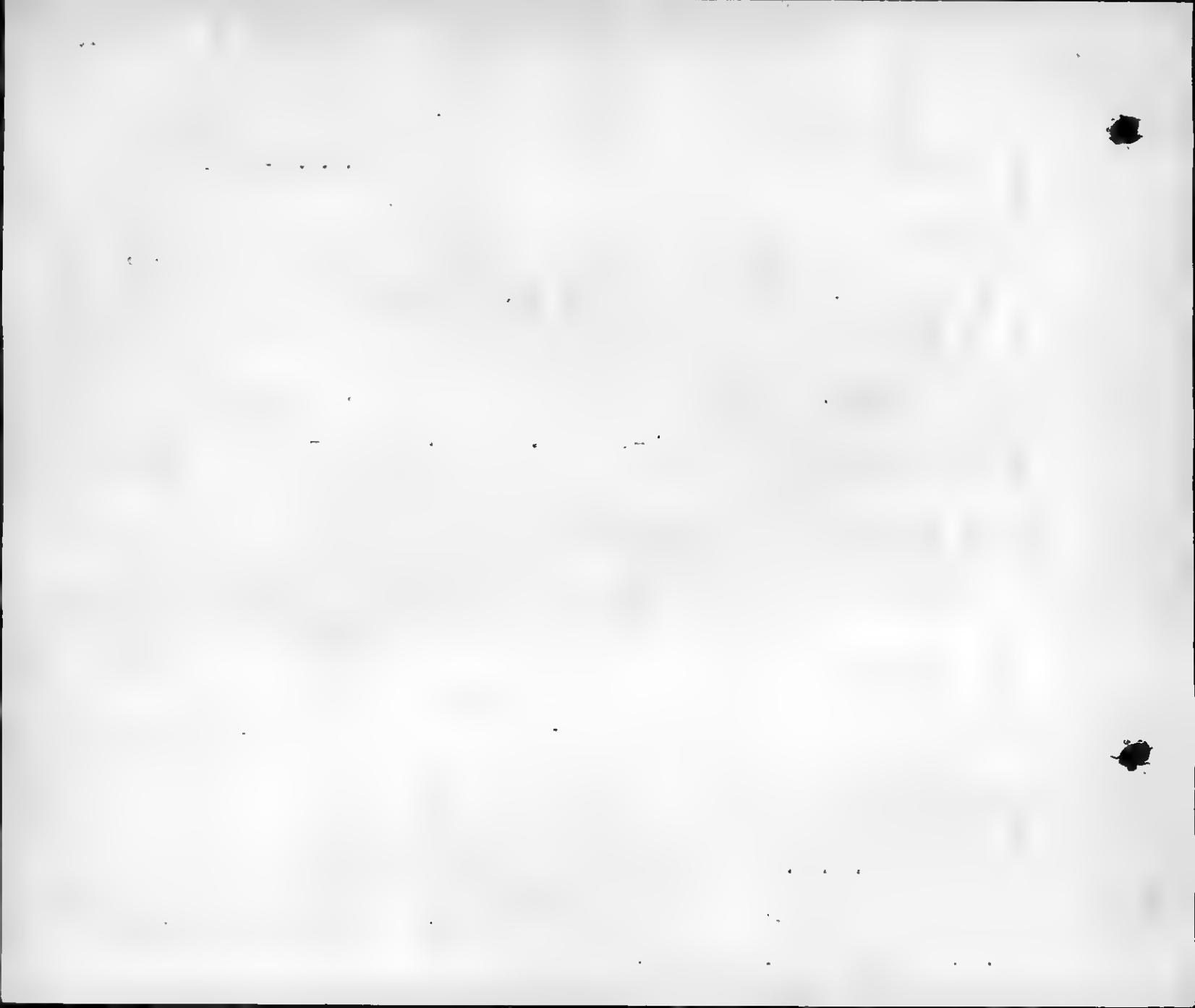
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your Funeral Director; Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>		c. LENGTH OF STAY IN lb <b>Lewistown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont-R.F.D.#1-Rural</b>	
3. NAME OF DECEASED (Type or print) <b>EVELYN</b>		First <b>MARIE</b>	Middle <b>DELAUDER</b>
4. DATE OF DEATH <b>May 10, 1958</b>	Month <b>May</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1916</b>
9. AGE (In years last birthday) <b>42</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Baking Company</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Silas V. Stockman</b>		14. MOTHER'S MAIDEN NAME <b>Virgie H. Brandenburg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-24-1661</b>	
17. INFORMANT <b>Mr. Silas V. Stockman- Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Fracture of right wrist</b> DUE TO (c) <b>Fracture of frontal bone</b>  INTERVAL BETWEEN ONSET AND DEATH <b>Below</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile runs into electric</b>	
20c. TIME OF INJURY Hour <b>1:30</b>		20d. INJURY OCCURRED White <b>at work</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 11</b>		20f. (City or town) <b>Dr. Hanover</b>	
(County) <b>MD</b>		(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>5/12/58</b>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>Chase</b>	
		24b. REGISTRAR'S SIGNATURE <b>Chase</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

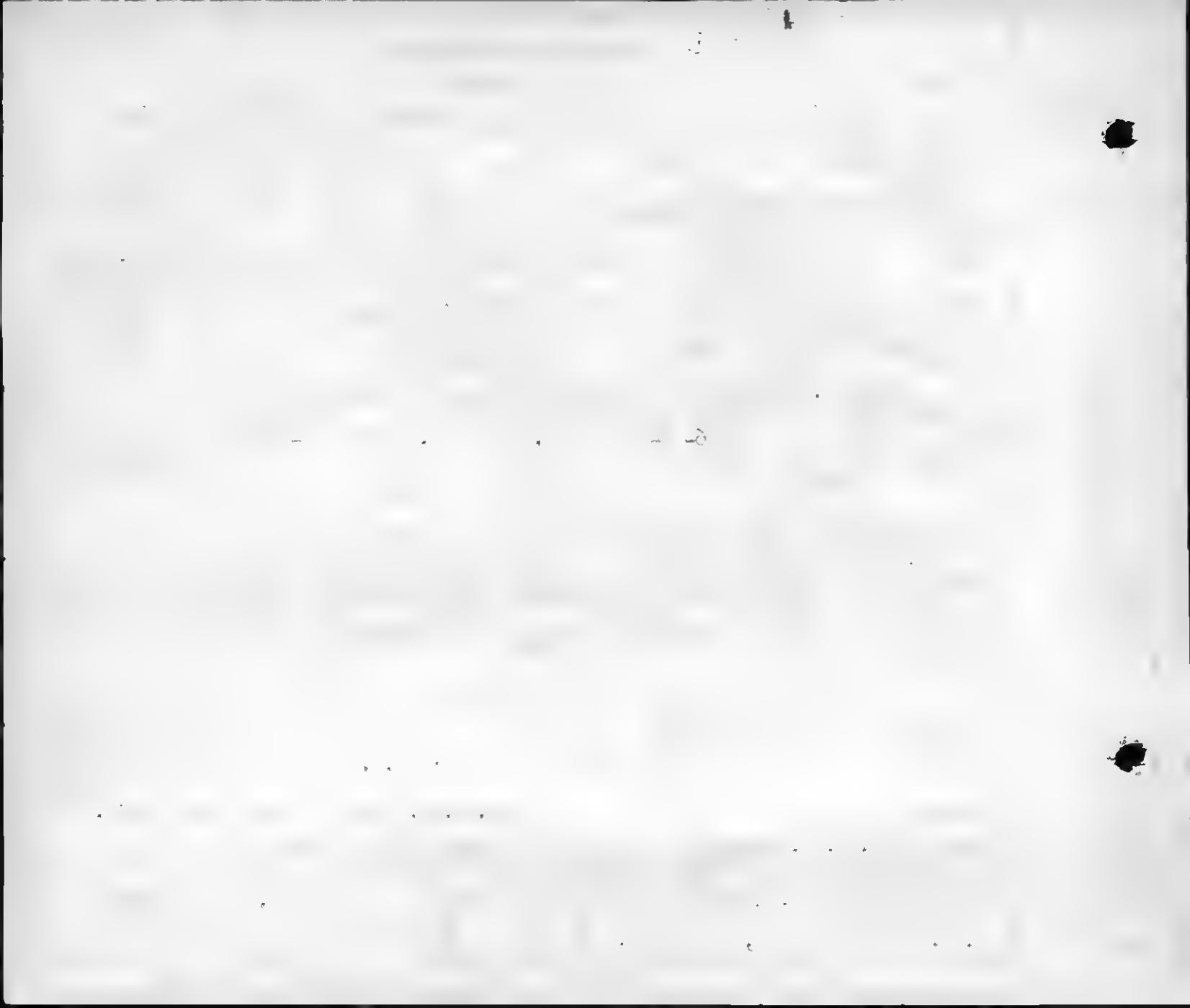
## 5672 CERTIFICATE OF DEATH

Reg. Dist. No. 45670

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>202 West 12th Street</b>		e. STREET ADDRESS <b>202 West 12th Street</b>	
3. NAME OF DECEASED (Type or print) <b>GLENN</b>		First <b>GLENN</b>	Middle <b>MARIE</b>
4. DATE OF DEATH <b>May 21, 1958</b>		Last <b>DETERDING</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 4, 1922</b>		9. AGE (in years last birthday) <b>36</b> yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. FATHER'S NAME <b>Frank G. Remsberg</b>	
13. MOTHER'S MAIDEN NAME <b>Marie Renn</b>		14. FATHER'S NAME <b>Frank G. Remsberg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>216-22-9202</b>	17. INFORMANT <b>Mr. Samuel F. Deterding-Same as item #1</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS.</b>	
1750 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <b>Undifferentiated Ca ovary</b>		3 MOS	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Frederick</b> , 1958, to <b>21 May</b> , 1958, that I last saw the deceased alive on <b>20 May</b> , 1958, and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles H. Conley</i>		ADDRESS (Street, city or town, state) M.D. <b>Physician's Name: Charles H. Conley</b> Professional Building, 5/23/58	
PHYSICIAN'S NAME (Type) <b>Dr. C. H. Conley</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick,</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 1958</b>	24b. REGISTRAR'S SIGNATURE <i>John L. Lewis</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5673

## CERTIFICATE OF DEATH

05671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>MARTIN</b>	Middle <b>L</b>	Last <b>DEVILBISS</b>	4. DATE OF DEATH <b>May</b>	Month <b>3</b>	Day <b>1958</b>	Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1882</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Devilbiss</b>			14. MOTHER'S MAIDEN NAME <b>Laura Buffington</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Elmer Krise, 365 E. King St., Littlestown,</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>Myocardial Infarct</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>			
		<b>Aterosclerosis</b>				<b>24 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Middlebury</b>		(County) <b>Middlebury</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Apr 28, 1958</b> to <b>May 2, 1958</b> , that I last saw the deceased alive on <b>May 2, 1958</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>H. F. Krise</b>									
PHYSICIAN'S NAME (Type) <b>Horace F. Kline</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Middlebury Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middlebury, Maryland</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b>		ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 5

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **05672**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colombus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>502 Annadale Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>LeRoy</b>	Last <b>Dickson</b>	4. DATE OF DEATH <b>May 20, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1914</b>	9. AGE (In years) <b>44 yrs.</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months <b>4</b> Days <b>11</b>
				IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>

10a. USUAL OCCUPATION (Give kind of work done) <b>Textile Metal Co. Sales Manager</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Hilton T. Dickson</b>	14. MOTHER'S MAIDEN NAME <b>Augusta Kammer</b>	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b>		
861X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____		
DUE TO		
(c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

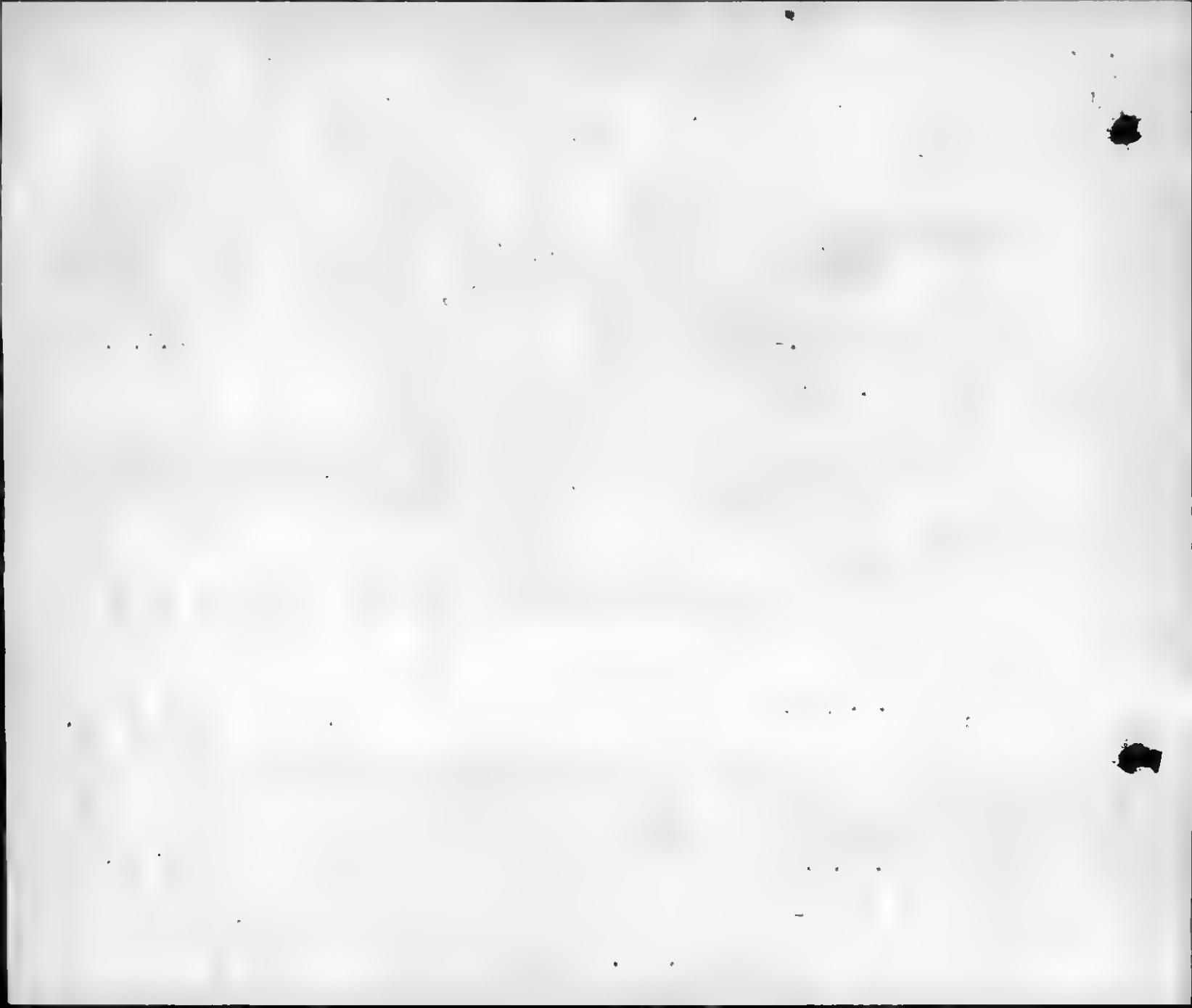
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. INJURY SURROUNDED (Indicate nature of injury in Part I or Part II of item 18.) <b>Airplane collided in air</b>		
20c. TIME OF INJURY <b>11:45 a.m.</b> Month, Day, Year <b>5-20-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
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ACTUAL SIGNATURE <i>B.O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>May 20, 1958</b>
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>	22b. DATE THEREOF <b>May 21-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rutherford Funeral Home</b>	22d. LOCATION (City, town, or county) (State) <b>Colombus, Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Felt</i>	ADDRESS <b>Brunswick, Md.</b>	24a. REC'D BY REGISTRAR <b>May 26 '58</b>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. Forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-travel permit. File pages 1 and 2 with the register prior to burial or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5674 CERTIFICATE OF DEATH

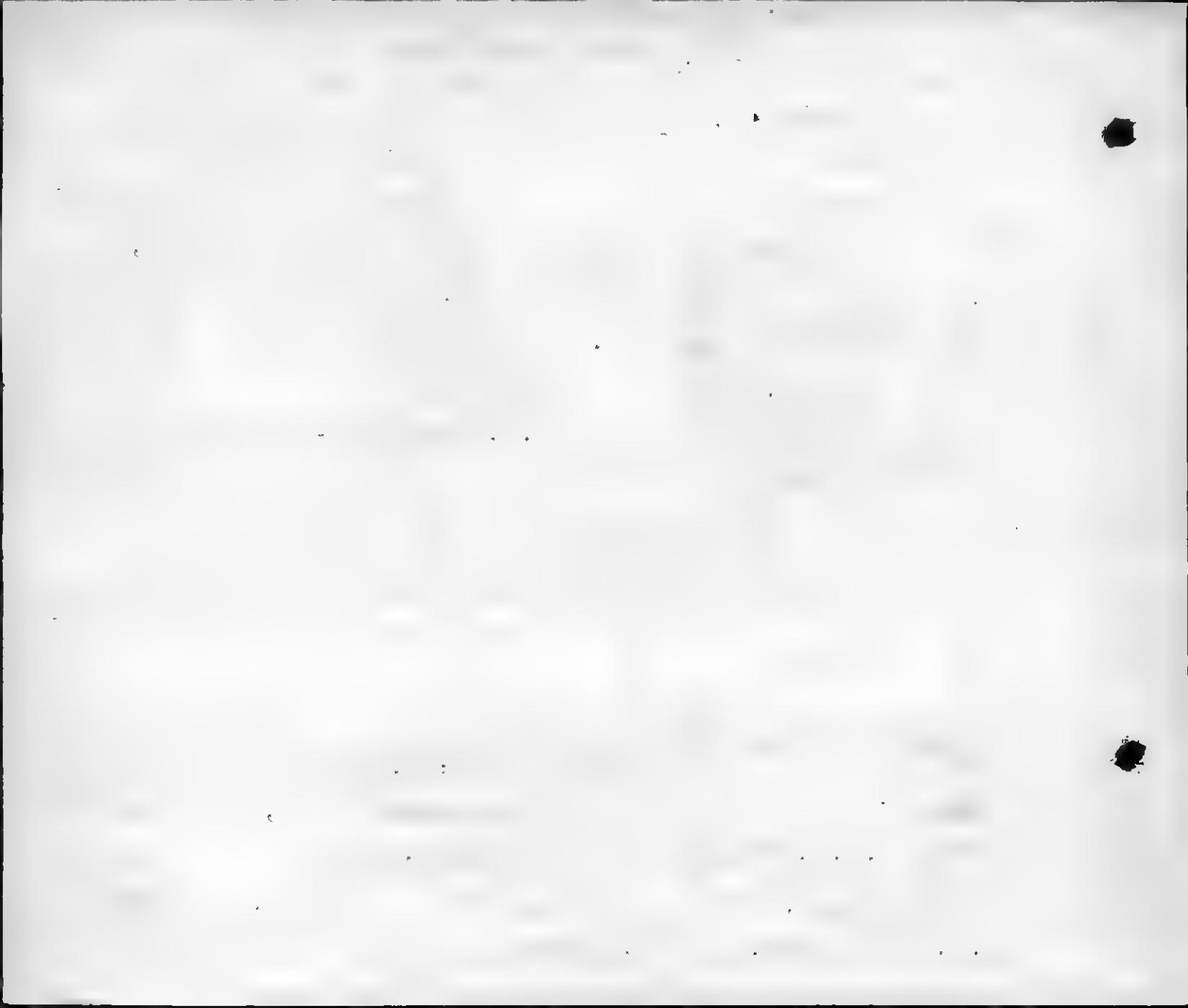
Reg. Dist. No.

05673

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and promptly event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 East Patrick Street</b>		d. STREET ADDRESS <b>123 East Patrick Street</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ELMER</b>	Middle <b>EUGENE</b>	Last <b>DIXON</b>	4. DATE OF DEATH <b>May 21, 1876</b>	Month <b>May</b>	Day <b>5,</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1876</b>	9. AGE (In years last birthday) <b>81</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner &amp; Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas O. Dixon</b>			14. MOTHER'S MAIDEN NAME <b>Julia Hiteshew</b>			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No.</b>		17. INFORMANT <b>Mrs. F. Russell Young- Same as Item #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4022.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				<b>Angina</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						57 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1957, to <b>May 5</b> , 1958, that I last saw the deceased alive on <b>May 5</b> , 1958, and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building, Frederick, Maryland</b>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>5/6/1958</b>					
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b>		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Asst. Secy.</b>



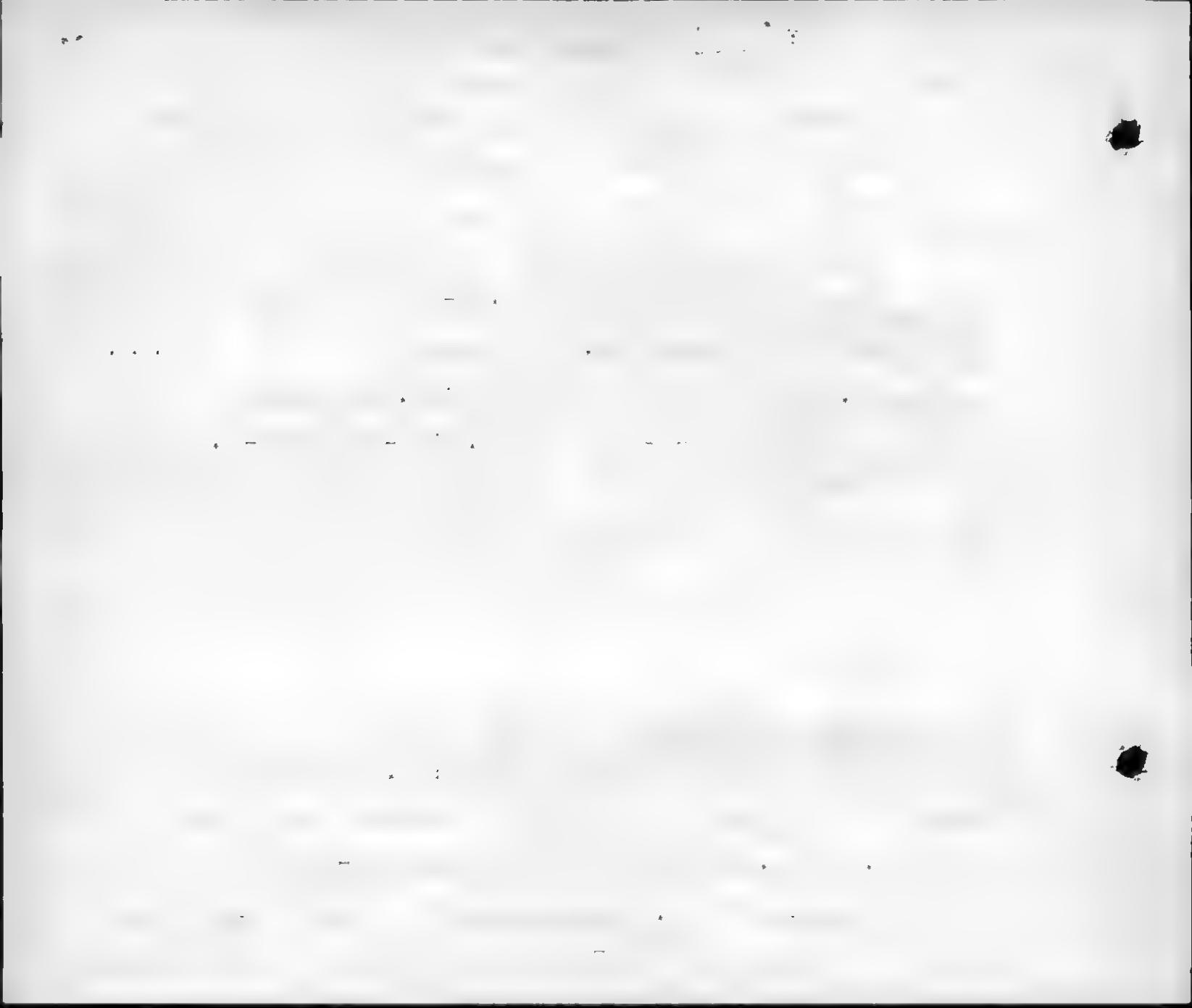
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5675 CERTIFICATE OF DEATH

Reg. Dist. No.

05674

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Elsie</b>	Middle <b>Leona</b>	Last <b>Dixon</b>		
4. DATE OF DEATH	Month <b>May</b>	Day <b>29th</b>	Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>Widow</b>	8. DATE OF BIRTH <b>Jan. 18-1899</b>		
9. AGE (In years last birthday) <b>59 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>		
13. FATHER'S NAME <b>Willard R. Hall</b>	14. MOTHER'S MAIDEN NAME <b>Lillie A. Fox (living)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>220-18-2421</b>	17. INFORMANT <b>Forest M. Dixon- New Market-Md. (Husband)</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial embolism (Cerebral and femoral arteries)</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Mural thrombi in left heart</b> 4-5 Years DUE TO (c) <b>Old rheumatic heart disease</b> app-45 Years					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frederick Shopping Center</b>	(County) <b>Maryland</b>	(State)
21. I certify that I attended the deceased from <b>May 14</b> , 19 <b>56</b> , to <b>May 29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 28</b> , 19 <b>58</b> , and that death occurred at <b>2:10A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick Shopping Center</b> DATE SIGNED					
ACTUAL SIGNATURE <b>Ralph L. Michels</b>	M.D.				
PHYSICIAN'S NAME (Type) <b>Dr. Ralph L. Michels</b>	Frederick-Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 31-1958</b>	22c. NAME OF CEMETERY OR CREMATORIY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick-Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Cline &amp; Son</b>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Q. Leach</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5676 CERTIFICATE OF DEATH

Reg. Dist. No.

05675

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>35 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>713 North Market Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>WOOD</b>	Last <b>FLETCHER</b>	4. DATE OF DEATH <b>May 8, 1958</b>	Month <b>May</b>	Day <b>8</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 29, 1896</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Window Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Peoples Drug Store</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther K. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Alice Wood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-1668</b>		17. INFORMANT <b>Mrs. Ann H. Fletcher—Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Rupture of abdominal aorta aneurysm</b> DUE TO (c) <b>Generalized (Severe) Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>May</b>	Doy <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>East Church Street</b>	(County)	(State)
21. I certify that I attended the deceased from <b>5-7, 1958</b> , to <b>5-8, 1958</b> , that I last saw the deceased alive on <b>5-8, 1958</b> , and that death occurred at <b>3:15A M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert S. Turner, Jr.</i>	ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b>						DATE SIGNED <b>5/9/58</b>
PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Turner, Jr.</b>	Frederick, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Alv. each</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5677

## CERTIFICATE OF DEATH

05676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Burkittsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Edgar C.</b>	Middle	Last	4. DATE OF DEATH	Month <b>May</b> Day <b>27</b> Year <b>1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27- 4-1888</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Martin H. Flook</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Alexander</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Oscar Flook, Brunswick, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		<b>Acute Coronary Thrombosis</b> <b>24 hr.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		<b>Anterior Lateral Heart disease</b> <b>5 yrs +</b>			
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/27</b> , 1958, to <b>5/27</b> , 1958, that I last saw the deceased alive on <b>5/27</b> , 1958, and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4 E. Church St</b> <b>Baltimore Md</b>			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		DATE SIGNED <b>5/28/58</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-30-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arnaldstown</b>	
22d. LOCATION (City, town, or county) <b>Nr. Burkittsville, Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feith</b>		ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alvarez</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should remain with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



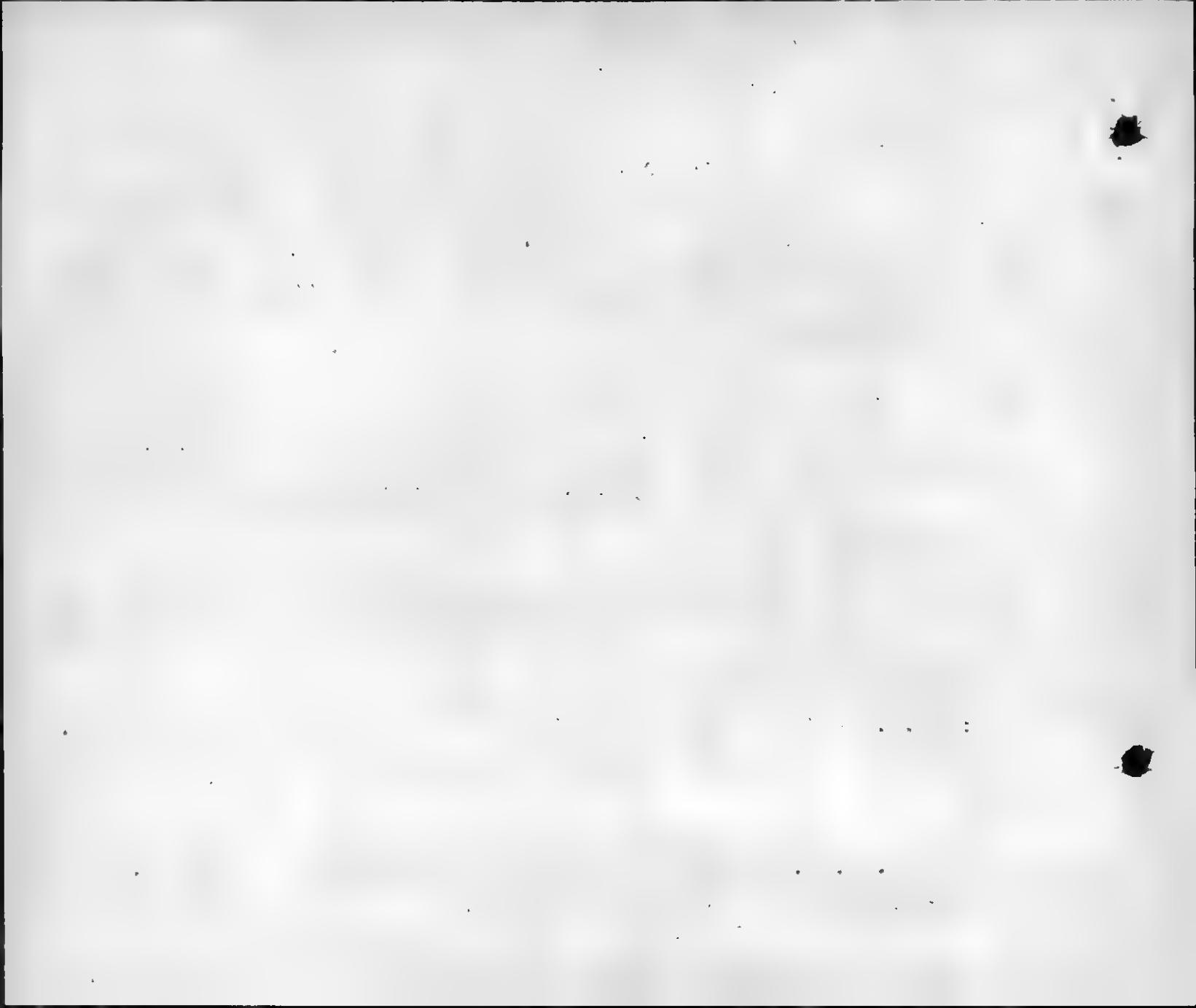
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05677

Reg. Dist. No.

X #1		MAY 20 1958							
1. PLACE OF DEATH a. COUNTY Frederick		5708		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL - Brunswick		c. LENGTH OF STAY IN lb		a. STATE Md.		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
3. NAME OF DECEASED (Type or print)		First Gertrude	Middle 	Last Gliedman	4. DATE OF DEATH	Month May	Day 20	Year 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1920		9. AGE (in years) 49	IF UNDER 1 YEAR Months 38	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Turlock, Calif.			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Karl Eppstein			14. MOTHER'S MAIDEN NAME Anna Klaff						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.			17. INFORMANT			Address Mr. Karl Eppstein, Millers, Balt Co., Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple fractures and injuries</u> DUE TO <u>8 am</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
; 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 11:45 a.m. 5-20 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air		20f. (City or town) Rural		(County) Frederick	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B. Thomas</i>		DATE SIGNED May 20, 1958							
EXAMINER'S NAME (Type) Dr. B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL, TRANSFER Burial 12/1/58		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORIAL Towson Park Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. Lee Tate		ADDRESS Brunswick Md		24d. REC'D BY REGISTRAR May 26 '58		24e. REGISTRAR'S SIGNATURE <i>G. Lee Tate</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.  
 FORWARD to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



#6

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Film G229 5/26/58 mb

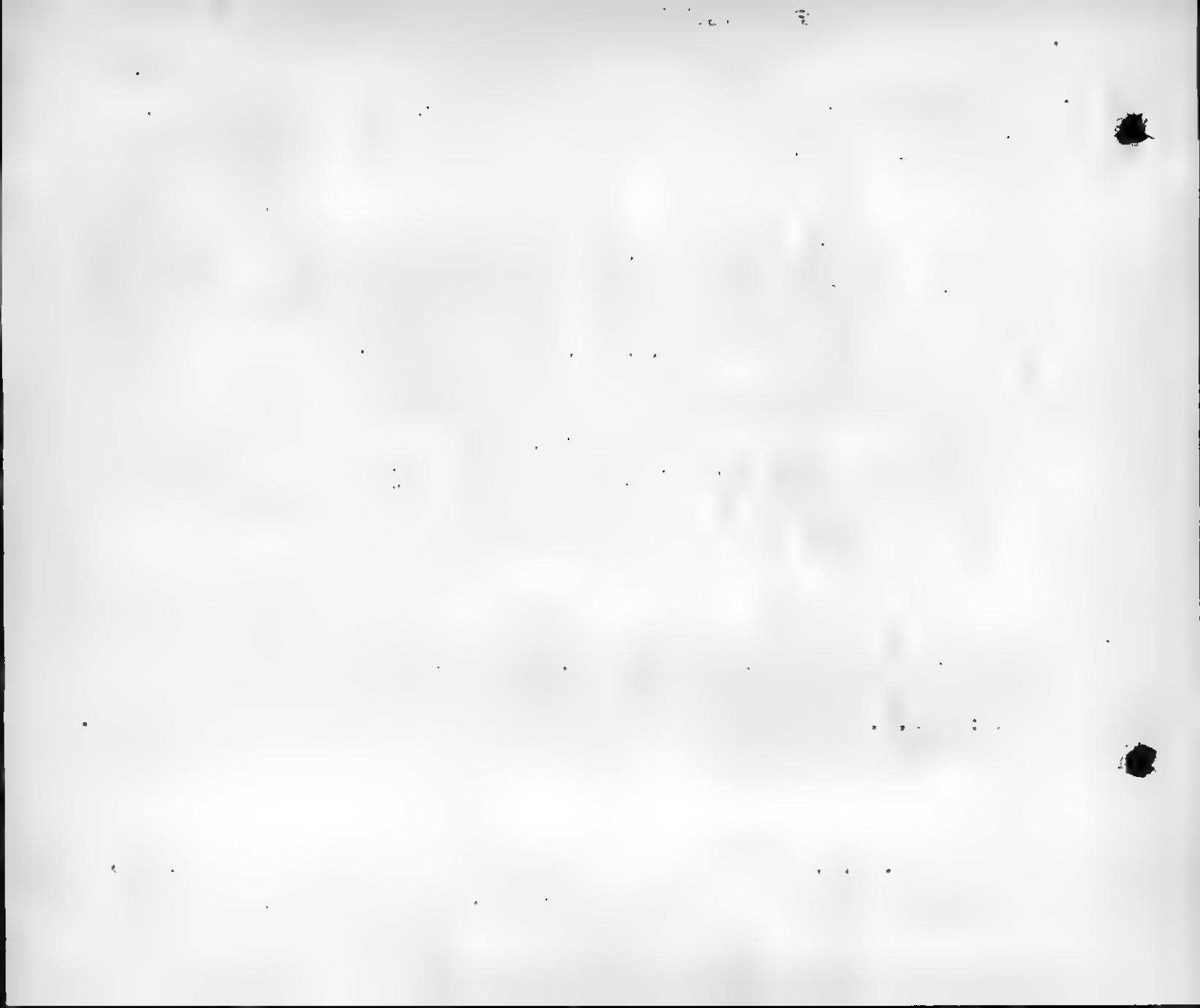
05678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> 5719 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Brunswick</b>		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		d. STREET ADDRESS <b>613 Goucher Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lester</b>	Middle <b>H.</b>	Last <b>Gliedman</b>
4. DATE OF DEATH	May	Month	20 Day 1958 19
5. SEX	6. COLOR OR RACE <b>Male</b> <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1919</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years <b>40</b> months <b>0</b> days <b>20</b> yrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <b>Associate Prof. Psychiatry-J.U.Univ.</b>	11. BIRTHPLACE (State or foreign country) <b>New York State</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Salig Gliedman</b>	14. MOTHER'S MAIDEN NAME <b>Rose Tobias</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>World War II</b>	17. INFORMANT <b>Mrs. Rose Gliedman, 541 Pelham Rd., New Rochelle,</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b>			
DUE TO <b>861X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b>			
DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Airplanes collided in air</b>		
20c. TIME OF INJURY Month, Day, Year <b>11:45 p.m. 5-20-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and Find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>	DATE SIGNED <b>May 20, 1958</b>		
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL, ENTOMBMENT <b>Cremation 5/21/58</b>	22b. DATE OF DEATH <b>5/21/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL FACILITY <b>Sickman Funeral Home</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Beth Lott</i>	ADDRESS <b>Brunswick Md</b>	24e. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>	24f. REGISTRAR'S SIGNATURE <i>Albert Smith</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5710 CERTIFICATE OF DEATH

05679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE									
<i>Frederick</i> MARYLAND		b. COUNTY <i>Md</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <i>CHARLES</i>	Middle <i>FRANKLIN</i>	Last <i>GRIMES</i>	4. DATE OF DEATH	Month <i>May</i>	Day <i>19</i>	Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 8, 1887</i>	9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>meat</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Charles Grimes</i>		14. MOTHER'S MARRIED NAME <i>Carolina W. Baker</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-10-2652</i>					
17. INFORMANT <i>Mrs Maude Grimes, Walkersville, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO <i>4 a.m.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute anterior myocardial infarction</i> DUE TO <i>Several</i> (c) <i>Arteriosclerotic cardio-vascular disease</i> DUE TO <i>years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Walkersville, Maryland</i>	20f. (City or town) <i>Walkersville</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May 14</i> , 19 <i>58</i> , to <i>May 19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 19</i> , 19 <i>58</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i> PHYSICIAN'S NAME (Type) <i>Ernest A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Maryland</i>		DATE SIGNED <i>May 20, 1958</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 5/20/58</i>	22b. DATE THEREOF <i>5/20/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Glade Cemetery</i>	22d. LOCATION (City, town, or county) <i>Walkersville, Md.</i>	(State) <i>Md.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.C. Barton, Walkersville, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAY 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05680

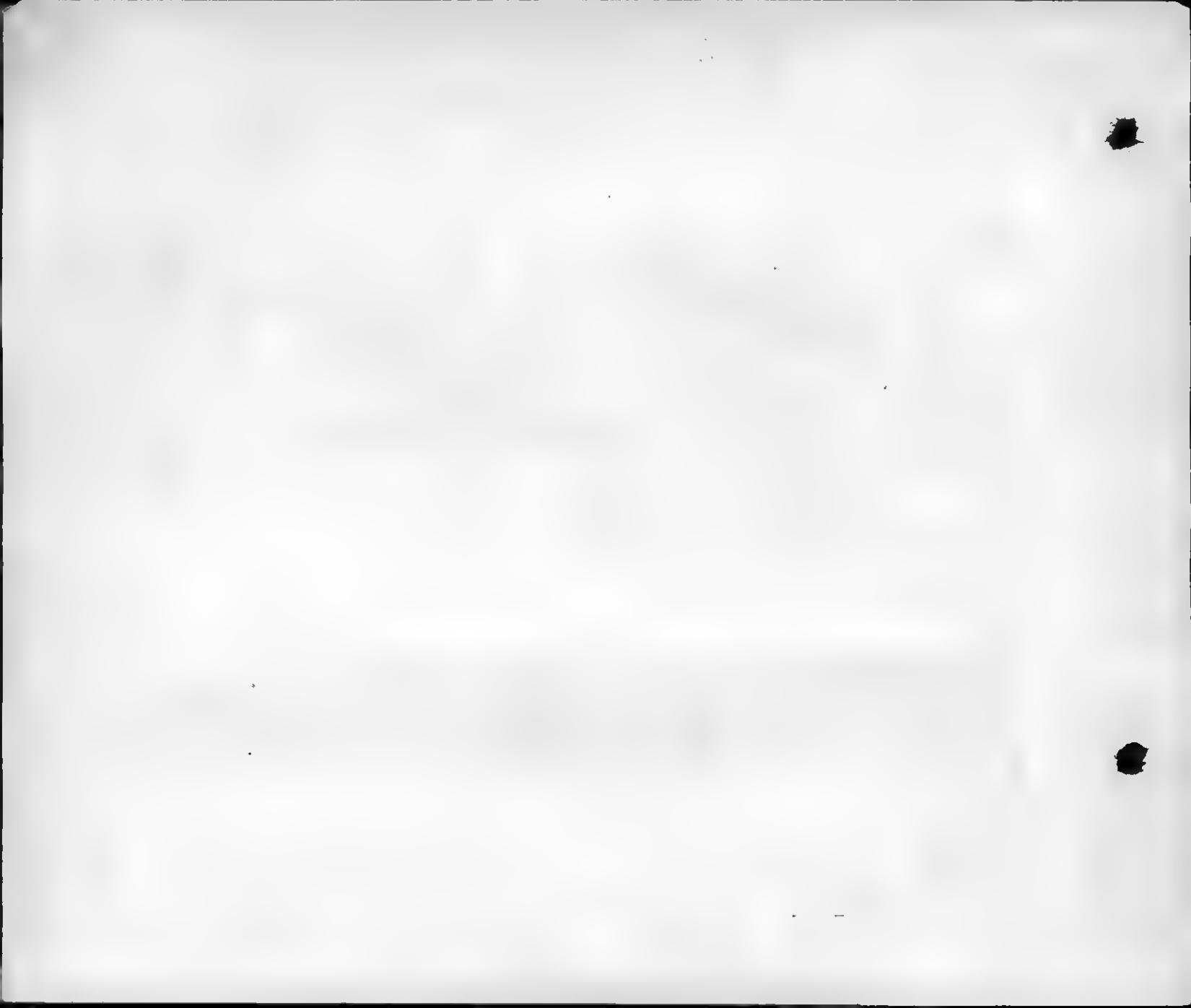
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		5711		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Frederick	
Thurmont		81		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		X Thurmont	
Frederick Memorial Hosp.		117 Water		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Howard Hermann Hahn				May 4	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, months, days, last birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 6, 1877	81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Carpenter		Hardware Clerk		Frederick Co U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Howard H. Hahn		Sarah Eiker		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-10-9421		Richard Hahn Address 907 Belize Road Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture base of skull & minutes			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
Struck by auto while walking on road					
20c. TIME OF INJURY Month, Day, Year Hour 130 p.m. 577 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				Street Thurmont Frederick Mt.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>		DATE SIGNED 577/58			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 5-10-58		22c. NAME OF CEMETERY OR CREMATORIUM United Cemetery	
				22d. LOCATION (City, town, or county) Thurmont, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond P. Creager Thurmont, Maryland					
ADDRESS					
24a. REC'D BY REGISTRAR DATE MAY 12 '58 24b. REGISTRAR'S SIGNATURE <i>Debrae Schub</i>					
VS. AT5ME 5M 2/57					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5678 CERTIFICATE OF DEATH

Reg. Dist. No. 05681

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] a. STATE <b>MARYLAND</b>		b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN lb <b>1 YR.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		d. STREET ADDRESS <b>23 SOUTH MAIN STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>CATHERINE</b>	Middle <b>E.</b>	Last <b>HOOVER</b>	4. DATE OF DEATH <b>May 29 1958</b>	Month <b>May</b>	Day <b>29</b>	Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/75</b>	9. AGE (In years lost birthday) <b>82</b> yr.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN H. HERB</b>		14. MOTHER'S MAIDEN NAME <b>MARY SEISS</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>REV. CYRIL HOOVER</b>		Address <b>UNION BRIDGE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>55ix</b>		<b>Cerebral Hemorrhage</b>					<b>1 WK</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		<b>Hypertensive Vascular disease</b>					<b>5 years+</b>		
DUE TO <b>55ix</b>									
(c)		<b>Atherosclerosis, generalized</b>					<b>5 years+</b>		
DUE TO									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>MARYLAND</b>	(County) <b>MARYLAND</b>	(State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>MAY 26, 1958</b> , to <b>MAY 29, 1958</b> , that I last saw the deceased alive on <b>MAY 29, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>MARYLAND</b>		
ACTUAL SIGNATURE <b>Henry V. Chase</b>		M.D. <b>4 E. Church</b>					DATE SIGNED <b>5/29/58</b>		
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		<b>Frederick Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town or county) <b>Hagerstown, Md.</b>		(State) <b>MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Kornmant, Hagerstown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detachable and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5679

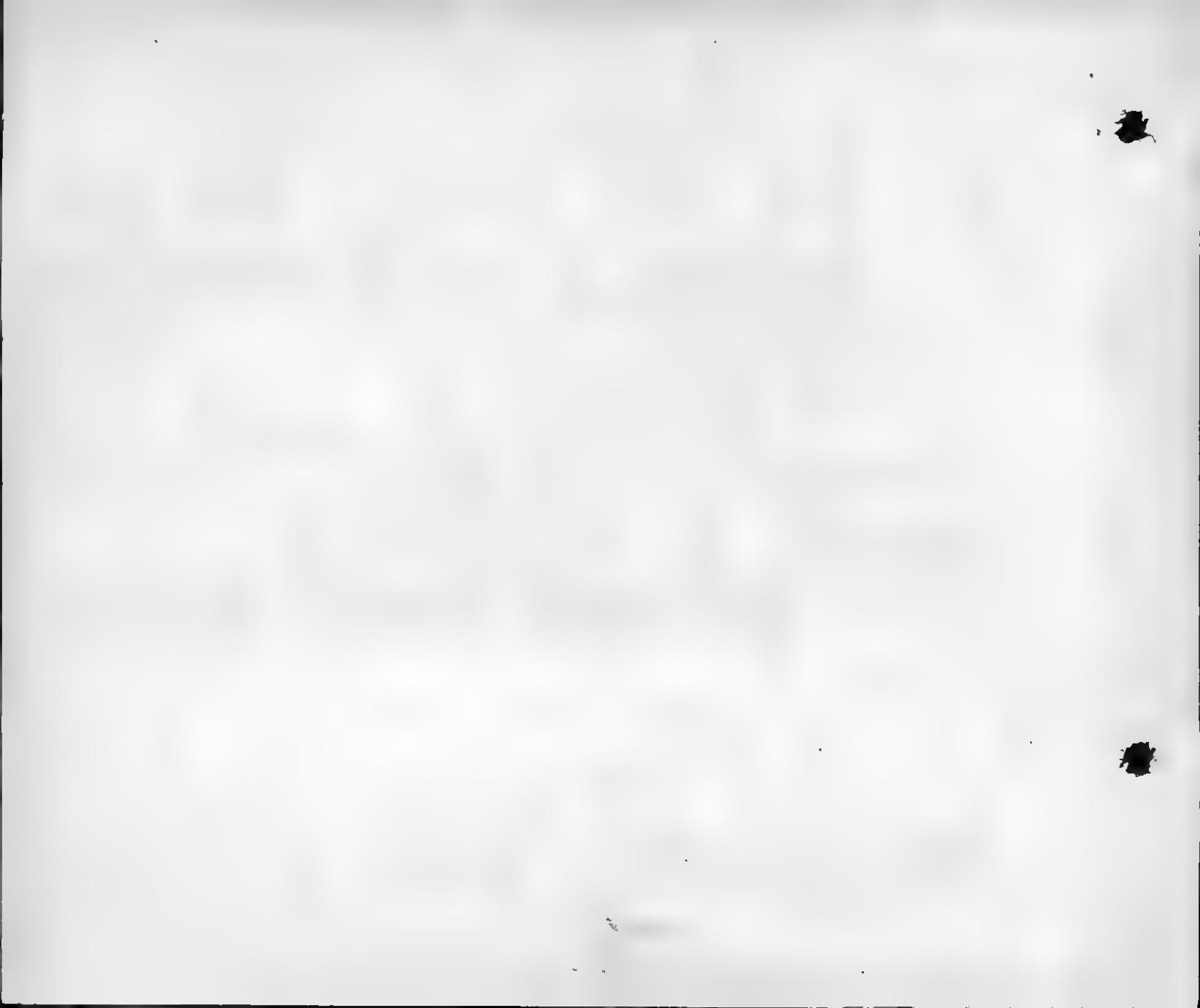
## CERTIFICATE OF DEATH

05682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i>		a. STATE	<i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <i>22 hours 45 min</i>	
<i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Frederick Memorial Hospital</i>		<i>501 Brunswick Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Glen</i>	Middle <i>Daniel</i>	Last <i>Hause</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>22</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 21, 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address: 501 Brunswick St., Mother - 501 Brunswick St.</i>	
13. FATHER'S NAME <i>Glen Daniel Butts</i>		14. MOTHER'S MAIDEN NAME <i>Eileen Thompson House</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>—</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Feder. 11 telecon.</i>	
DUE TO <i>P. rem. times</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>—</i>			
DUE TO <i>—</i>			
(c) <i>—</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>21 May 1958</i> to <i>27 May 1958</i> , that I last saw the deceased alive on <i>22 May 1958</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. M. Powell</i>		ADDRESS (Street, city or town, state) <i>220 N. Market St.</i> DATE SIGNED <i>—</i>	
PHYSICIAN'S NAME (Type) <i>A. M. Powell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/23/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Luthan</i>		22d. LOCATION (City, town, or county) <i>Brooksville Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. H. Felt</i>		ADDRESS <i>Brunswick Maryland</i>	
24a. REC'D BY REGISTRAR <i>MAY 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Webster</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

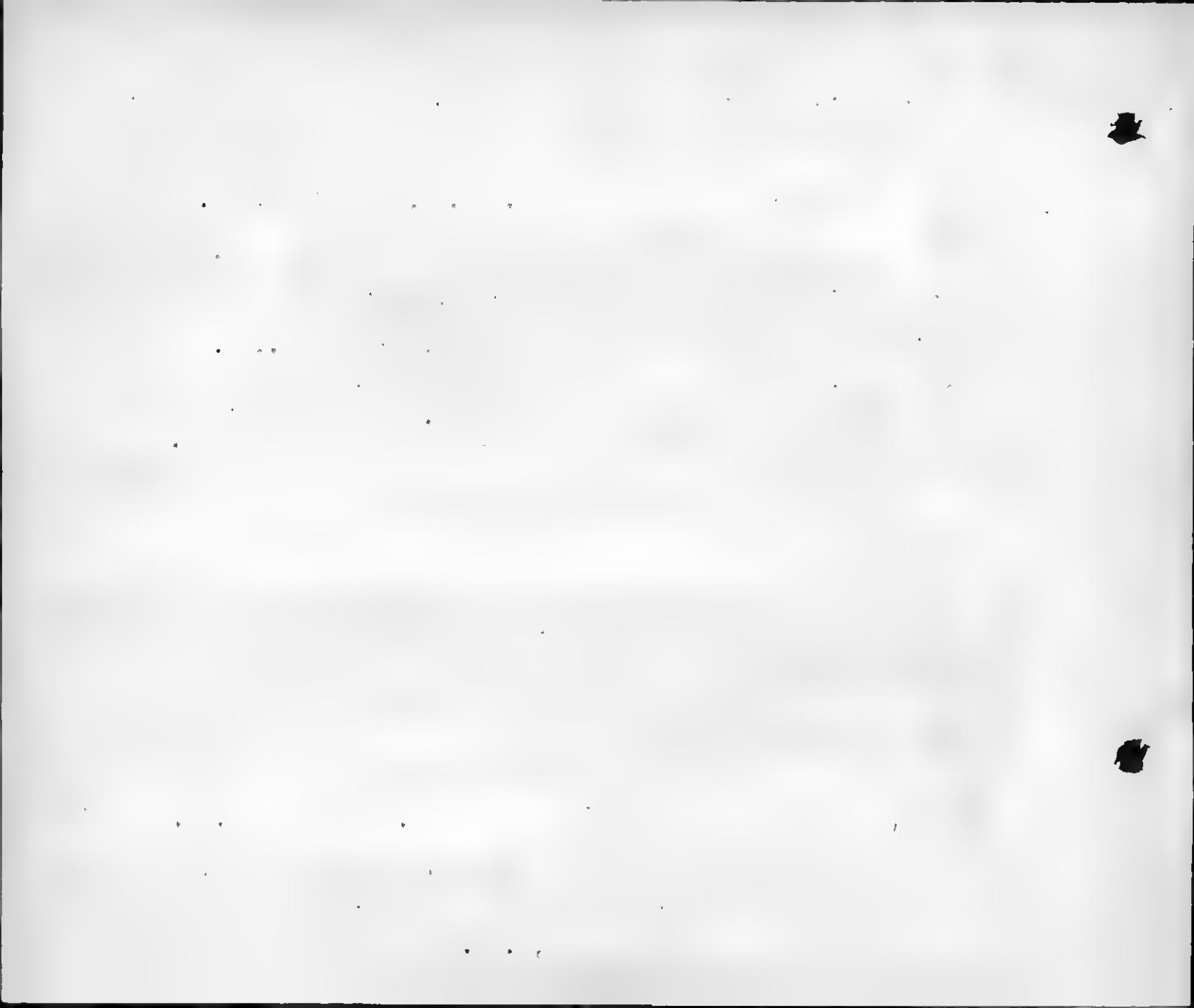
5712

## CERTIFICATE OF DEATH

05683

Reg. Dist. No.

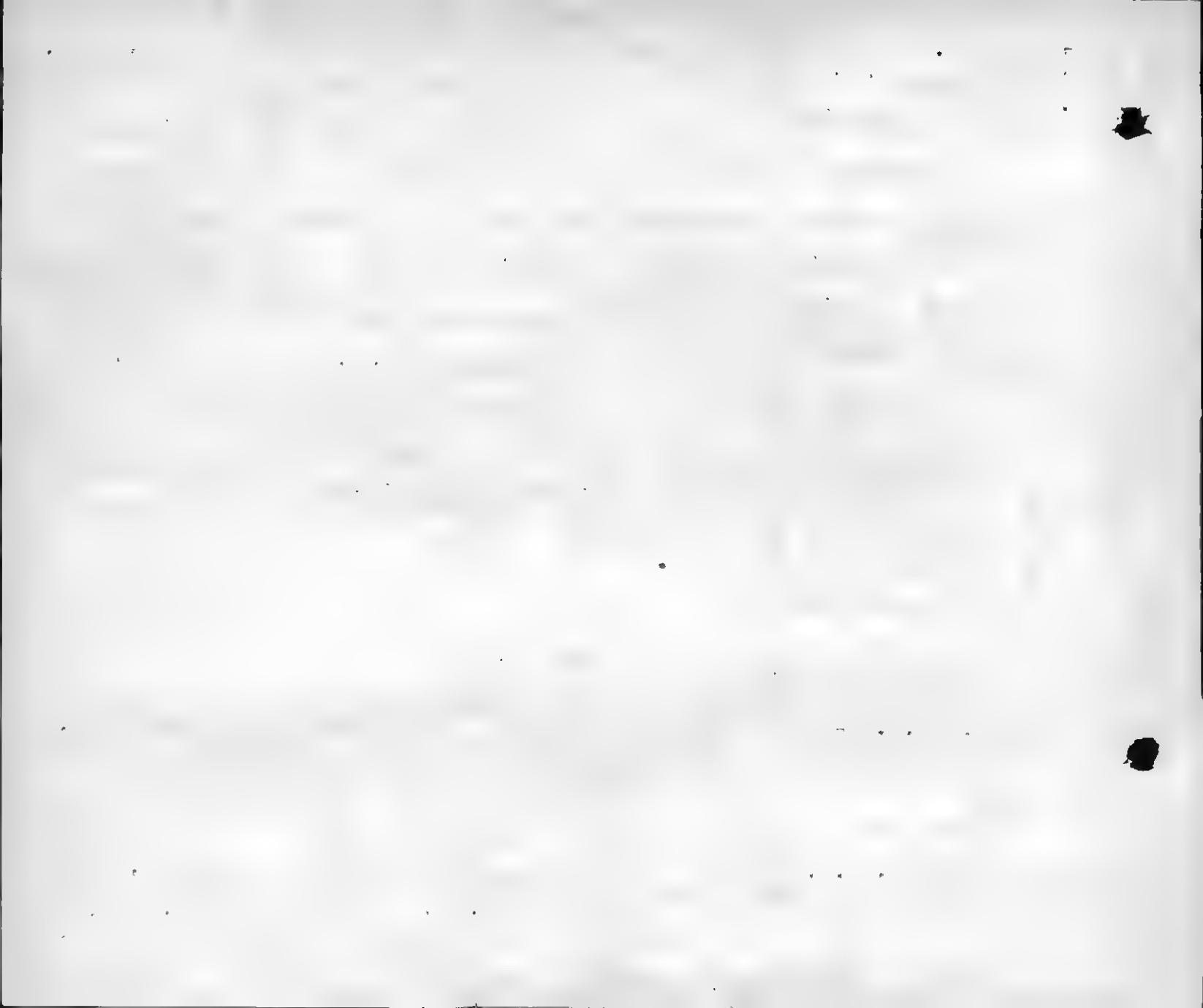
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosemont</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosemont</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				d. STREET ADDRESS <b>R.F.D.#1, Knoxville, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARTHA</b>		First <b>ORPHELIA</b>	Middle <b>HOWIE</b>	Last	4. DATE OF DEATH <b>May 15,</b>	Month <b>May</b>	Day <b>19</b>	Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 4, 1884</b>	9. AGE (In years less birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Swanton, Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Allan Garlitz</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fitzwater</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Marvin Younkins</b> Box 226, RFD #1, Knoxville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>									
INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>									
4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension of long standing. Asthma.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e. g. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Middleton</b>		(County) <b>Middle</b>	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>May 14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>58</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>115 E. Potomac Street, Brunswick</b>									
DATE SIGNED <b>5/16/58</b>									
ACTUAL SIGNATURE <i>Ralph M. Thompson</i>		M.D. <b>Ralph M. Thompson, M. D.</b>							
PHYSICIAN'S NAME (Type) <b>J. Donald Cocks</b>		ADDRESS <b>Harpers Ferry, W. Va.</b>							
22o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/17/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middleton, Maryland</b>		(State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Donald Cocks</i>		ADDRESS <b>Harpers Ferry, W. Va.</b>		24o. REC'D BY REGISTRAR DATE <b>MAY 19 '58</b>		24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>			



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 05684	
Items 2, 11, 13, 14, 15 Film G2296-2 58 et													
1. PLACE OF DEATH a. COUNTY 5713 MARYLAND <b>Frederick</b>												2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hamburg</b>	
c. LENGTH OF STAY IN 1b												d. STREET ADDRESS <b>59 Victory Avenue</b>	
												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year <b>Jessie Hunt May 20 1958</b>													
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
<b>Female</b>		<b>White</b>						26 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
<b>Plane Hostess</b>								<b>Buffalo, N.Y.</b>				<b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Hunt</b>												14. MOTHER'S MAIDEN NAME <b>Mary West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
<b>No</b>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: <b>Multiple fractures and injuries</b>													
IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b>													
DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____													
DUE TO													
(c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rural</b>		(County) <b>Frederick</b>		(State) <b>Md.</b>			
<b>11:45 a.m. 5-20 1958</b>				<b>Air</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>B.O. Thomas</b>												DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>													
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BUR. AL. CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5/27/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Morichville Prot. Ch.</b>		22d. LOCATION (City/town, or county) <b>Hamburg, New York</b>		(State) <b>N.Y.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Liles Brunswick Md.</b>		ADDRESS		24a. RECD' BY REGISTRAR <b>May 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Liles</b>							



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

#2

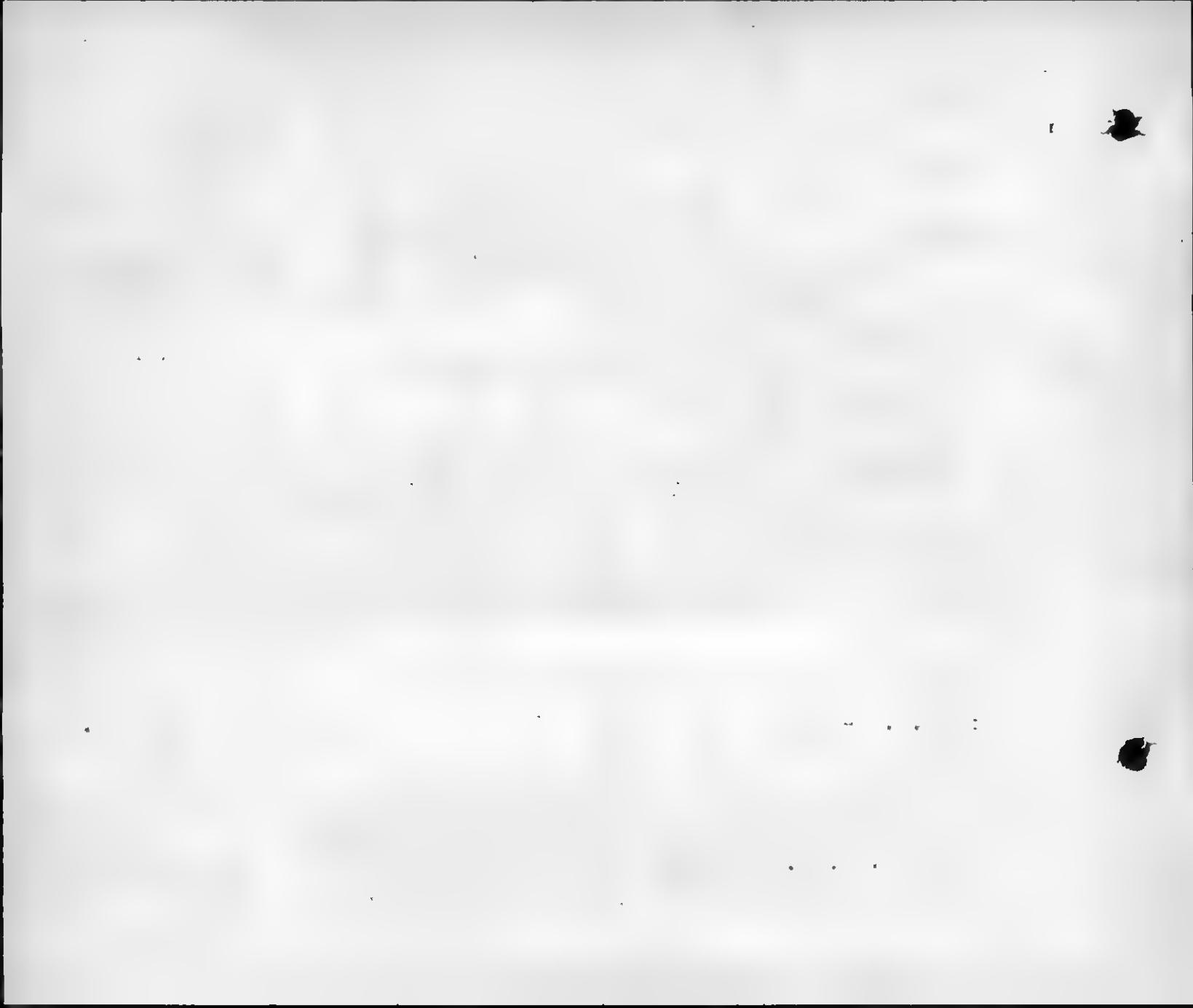
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05685.

5714		Items 2, 3, 11, 12, 13, 15 6/27/58 Film G-220 6-4-58 et	Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY		12. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) c. STATE New York b. COUNTY Suffolk	
Frederick		6/27/58	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
1769 Stein Drive		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Helen Irizarry		4. DATE OF DEATH Month Day Year May 20 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years July 30, 1933 12524 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plane Hostess	
10b. KIND OF BUSINESS OR INDUSTRY Capital Airlines		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Cosme Irizarry		14. MOTHER'S MAIDEN NAME Evrigueta Luiggi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 861X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Airplanes collided in air		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1:45 a.m. 5-20 58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) Air 20f. (City or town) (County) (State) Rural Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. B. O. Thomas		DATE SIGNED May 20, 1958	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/21/58	
22c. NAME OF CEMETERY OR CREMATORIAL Home		22d. LOCATION (City, town, or county) Long Island ??	
23. FUNERAL DIRECTOR'S SIGNATURE B. O. Thomas		24a. REC'D BY REGISTRAR ADDRESS	
		24b. REGISTRAR'S SIGNATURE	
		DATE MAY 26 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
5715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 2, 3, 10a, 11, 13, 14, 15 File No 2226-2-58 et Reg. Dist. No. 05686											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>—</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh 5</b> 75x 13							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>				c. LENGTH OF STAY IN 1b <b>1819 Noblestown Rd.</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1819 Noblestown Rd.</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Ruth</b>		Middle <b>McNelty</b>		Last <b>Johns</b>		4. DATE OF DEATH <b>May 20 1958</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>47 yrs.</b>		9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>McKeesport, Pa.</b>			
								12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert P. McNelty</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Elizabeth Freeman</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> DUE TO <b>861X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY <b>11:45 a.m. 5-20 1958</b>		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>AIR</b>		20f. (City or town) <b>Rural</b>		(County) <b>Frederick Md.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>May 20, 1958</b>									
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE OF REMOVAL <b>5-21-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>REINHAUER FUNERAL HOME</b>		22d. LOCATION (City, town, or county) <b>TOWNSBURG, Pa.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feltz Brunswick Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>(Elle E. Smith)</b>					



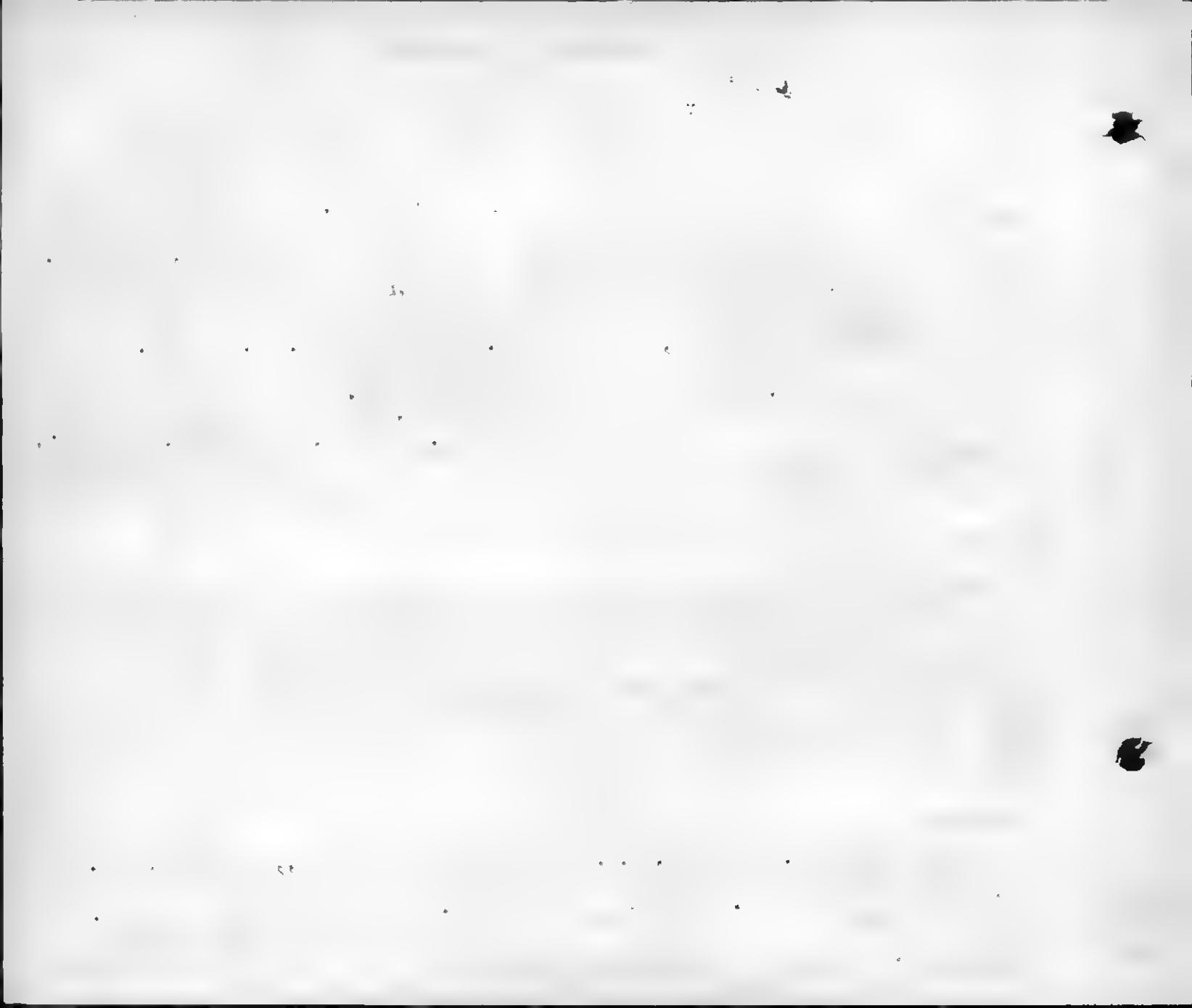
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5680 CERTIFICATE OF DEATH

05687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK,</b> <b>FREDERICK,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		b. COUNTY <b>FREDERICK</b>	
c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// FREDERICK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(EMPLOYEE) HOME FOR THE AGED</b>		d. STREET ADDRESS <b>115 Record St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MAID</b>	Middle <b>LILLY</b>	Last <b>KEFAUVER</b>
4. DATE OF DEATH	Month <b>MAY</b>	Day <b>24,</b>	Year <b>1958.</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1890</b>
9. AGE (In years last birthday) <b>67</b>	10. IF UNDER 1 YEAR Months <b>10</b>	11. IF UNDER 24 HRS. Days <b>4</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MATRON</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MATRON, HOME FOR AGED.</b>	
11. BIRTHPLACE (State or foreign country) <b>FREDERICK CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>WILLIAM C. KARN</b>		14. MOTHER'S MAIDEN NAME <b>CORA WHIPP.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. 17. INFORMANT (Son.) <b>WILLIAM L. KEFAUVER,</b> Address <b>506, Elm. Frederick.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>ARTERIO-SCLEROTIC HEART DIS.</b>		2 yrs (?)	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 <sup>50</sup> , to 24 MAY, 19 <sup>55</sup> , that I last saw the deceased alive on 20 MAY 19 <sup>55</sup> , and that death occurred at 8 <sup>30</sup> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles H. Conley Jr.</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Charles H. Conley Jr. M.D.</b>		Professional Bldg., Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURKETTSVILLE</b>		22b. DATE THEREOF <b>5/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>UNION, BURKETTSVILLE.</b>		22d. LOCATION (City, town, or county) <b>BURKETTSVILLE, MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey &amp; Son</i>		24a. REC'D BY REGISTRAR DATE MAY 29 '58	
ADDRESS <b>FREDERICK, MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <i>John J. Dailey</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05688

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, write the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Frederick MARYLAND		a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 40 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 639 Park Place		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
3. NAME OF DECEASED (Type or print) Chester		4. DATE OF DEATH May 18th 1958			
First Middle Last		Month Day Year			
5. SEX Male		6. COLOR OR RACE White			
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 7-1874			
9. AGE (In years last birthday) 83 yr.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist-Engineer- Railway		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Kesselring		14. MOTHER'S MAIDEN NAME Mary Poffenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-5995 17. INFORMANT Mr. Wm. Clifford Kesselring-Phila.-Pa.(Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 417.2 DUE TO <i>Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Laceration of Scalp</i> (c) Hour					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>B.O.Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5/21/58</i>	
EXAMINER'S NAME (Type) <i>B.O.Thomas</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Md.		24a. REC'D BY REGISTRAR DATE MAY 26 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alt. e. cline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5682

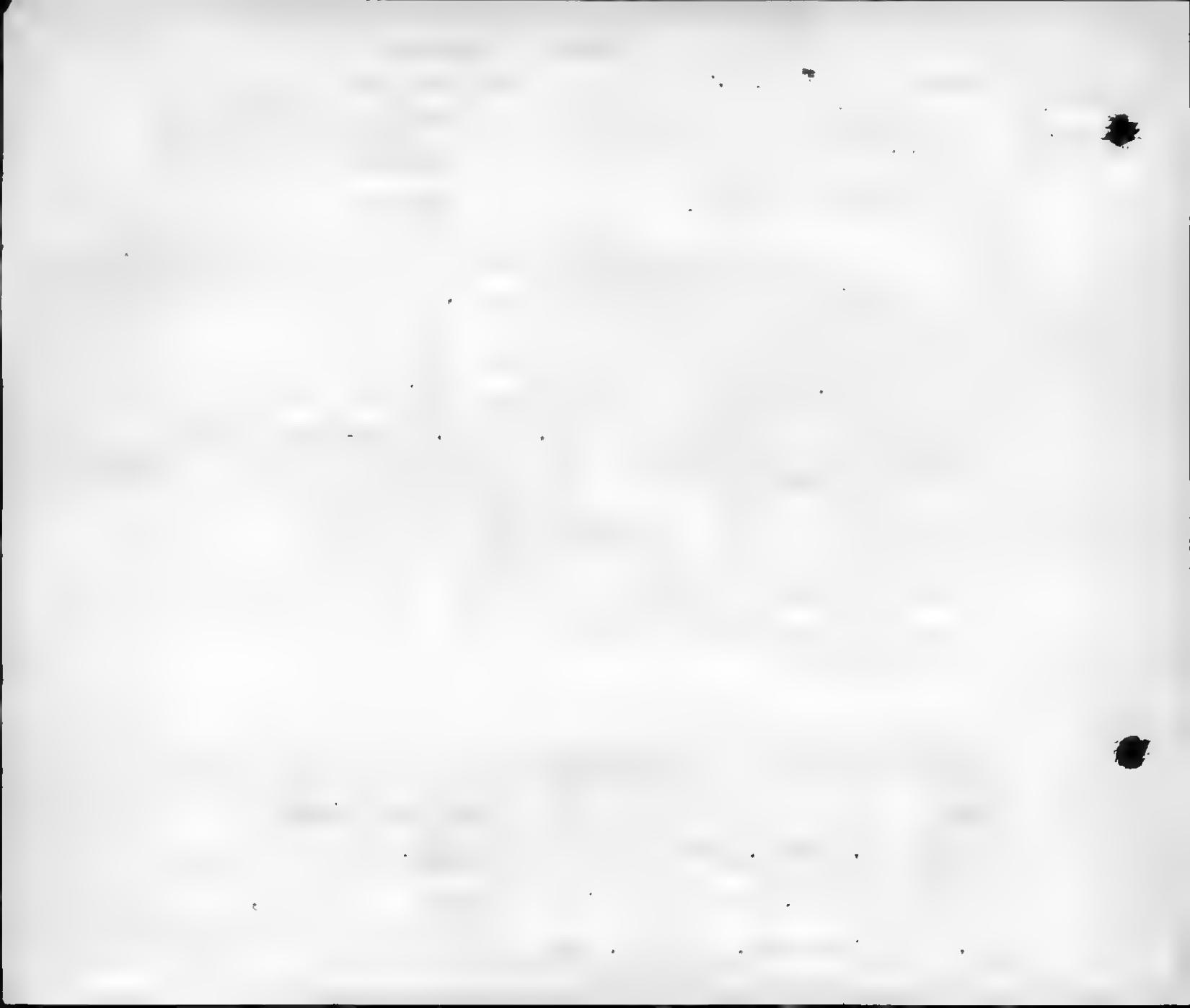
## CERTIFICATE OF DEATH

05689

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>525 Mary Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LYNN</b>	Middle <b>ELLEN</b>	Last <b>KUEHNE</b>	4. DATE OF DEATH <b>May 20, 1958</b>	Month <b>May</b>	Day <b>20</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1958</b>	9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph W. Kuehne</b>				14. MOTHER'S MAIDEN NAME <b>Merle Ann Emmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Ralph W. Kuehne—Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>Life</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Professional Building</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/19</b> , 1958, to <b>5/21</b> , 1958, that I last saw the deceased alive on <b>5/19</b> , 1958, and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <b>James B. Thomas</b> M.D. <b>Professional Building</b> DATE SIGNED <b>5/20/58</b>							
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b> Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick,</b> Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Alfred Enoch</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 5633      **CERTIFICATE OF DEATH**

Reg. Dist. No.

05690

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
Frederick Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
		LAWYER	Last
Milton O.			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
Aug. 25, 1882		IF UNDER 1 YEAR	IF UNDER 24 HRS
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Machinist		Farm Equip. Con. Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William E. Lawyer		Louisa Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		215-26-1900 Tolbert F. Lawyer	
17. INFORMANT		Address	
		Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 day	
464X		Pulmonary Embolism	
DUE TO		4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Phlebothrombosis	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Peptic ulcer	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 21</u> , 19 <u>58</u> , to <u>May 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
		DATE SIGNED	
ACTUAL SIGNATURE		Thomas E. Stone M.D. 44 3rd St 5-19-58	
PHYSICIAN'S NAME (Type)		Thomas E. STONE	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Luray		5-22-58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Blue Ridge Cem.		Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR	
Raymond E. Creager Thurmont, Md.		MAY 22 1958	
		24b. REGISTRAR'S SIGNATURE	
		Raymond E. Creager	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)  
5M 9/55

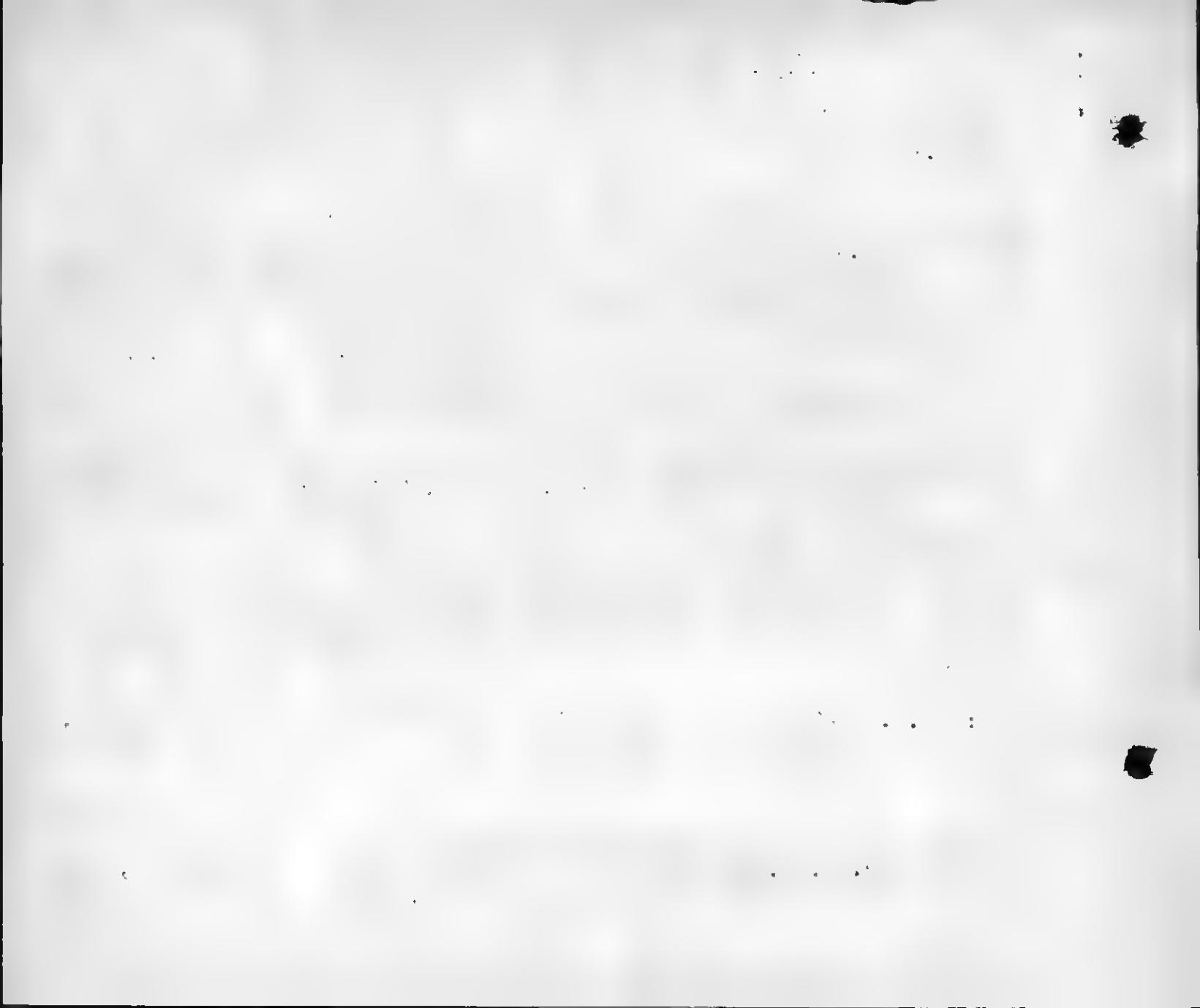
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 7, 11, 13, 14, 15 File #229 6-2-58 et

05691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>		c. LENGTH OF STAY IN lb		a. STATE <b>Pennsylvania</b>		b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b>				
3. NAME OF DECEASED (Type or print) <b>Jack</b>		First	Middle	Last	4. DATE OF DEATH <b>Levin</b>	Month <b>May</b>	Day <b>20</b>	Year <b>1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR: Months <b>0</b>	IF UNDER 24 HRS: Hours <b>0</b>	IF UNDER 24 HRS: Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Levin</b>				14. MOTHER'S MAIDEN NAME <b>Minnie (Last name not given)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiples fractures and injuries</b> INTERVAL BETWEEN ONSET AND DEATH 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20 58</b> 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b> 20f. (City or town) Rural 20g. (County) <b>Frederick</b> 20h. (State) <b>Md.</b>								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>B. O. Thomas</i> DATE SIGNED EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> 22b. DATE OF DEATH <b>5/21/58</b> 22c. NAME OF CEMETERY OR Crematory <b>Ralph Schugar Inc.</b> Cem. 22d. LOCATION (City, town, or county) Pittsburg (State) Pa.								
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feile</b>		ADDRESS <b>Brunswick Md.</b>		24a. REC'D BY REGISTRAR DATE <b>May 26 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5717

## CERTIFICATE OF DEATH

05692

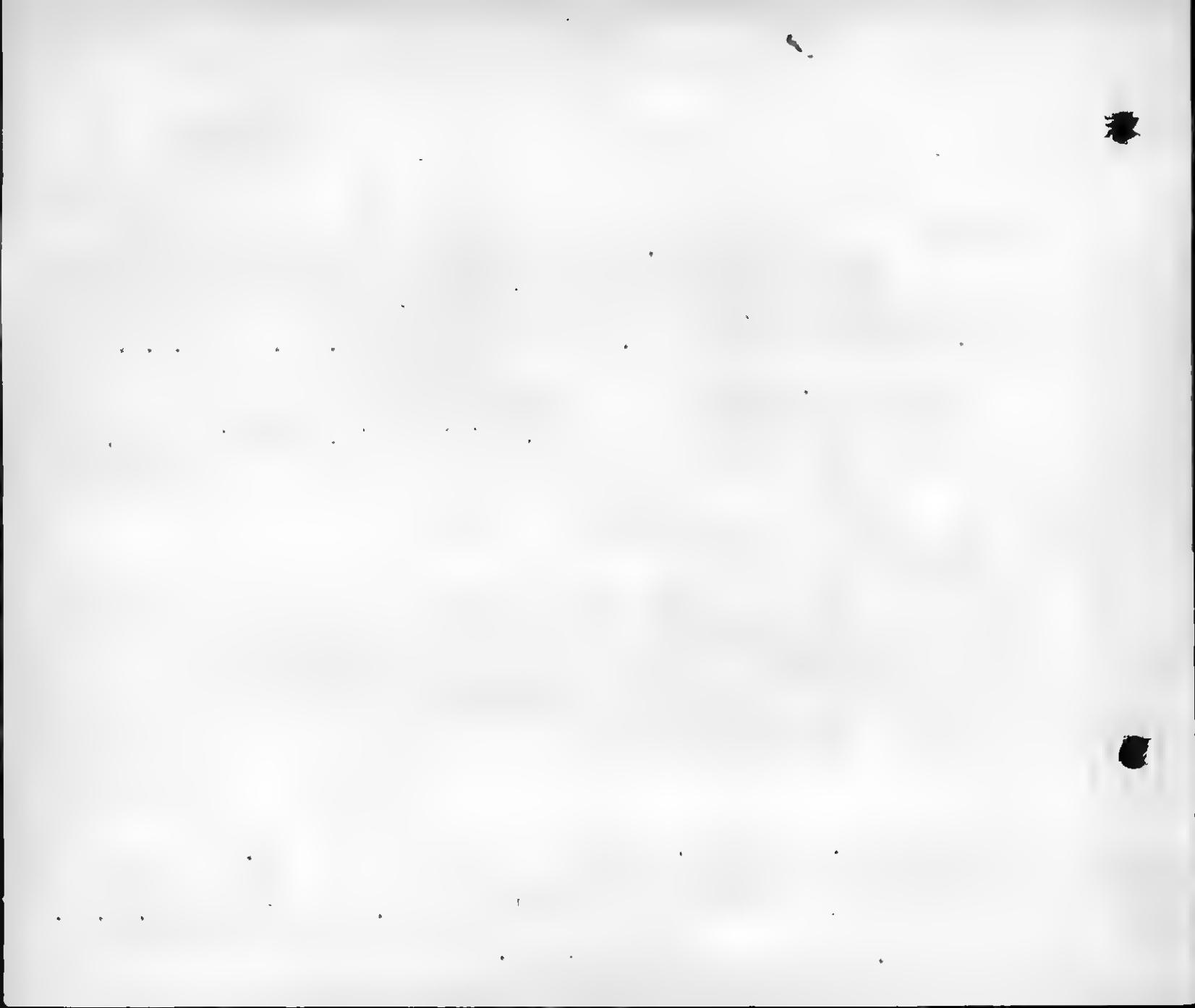
Reg. Dist. No.

Item 16, Film G-228 5/12/58.cav

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>		c. LENGTH OF STAY IN lb <b>73 years</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>		e. COUNTY <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 1</b>		f. STREET ADDRESS <b>Route # 1</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LEVIN</b>	Middle <b>T.</b>	Last <b>LEWIS</b>
4. DATE OF DEATH	Month <b>May</b>	Day <b>6</b>	Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 19, 1884</b>
			9. AGE (In years last birthday) <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Mdse.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob E. Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Celia Ann Hurley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-34-4021</b>	
17. INFORMANT Address <b>Mrs. Trixie Lewis, Myersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  DUE TO  (b) DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH <b>about 1 mo.</b>	
Cardio-vascular - renal disease generalized arteriosclerosis		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1958</b> , to <b>May 6, 1958</b> , that I last saw the deceased alive on <b>May 3, 1958</b> , and that death occurred at <b>712 M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Kenneth C. Henson</b> M.D. ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>May 7, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Kenneth C. Henson</b>		Middletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Grossnickle's</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Aut. death</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be copied with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5718 CERTIFICATE OF DEATH

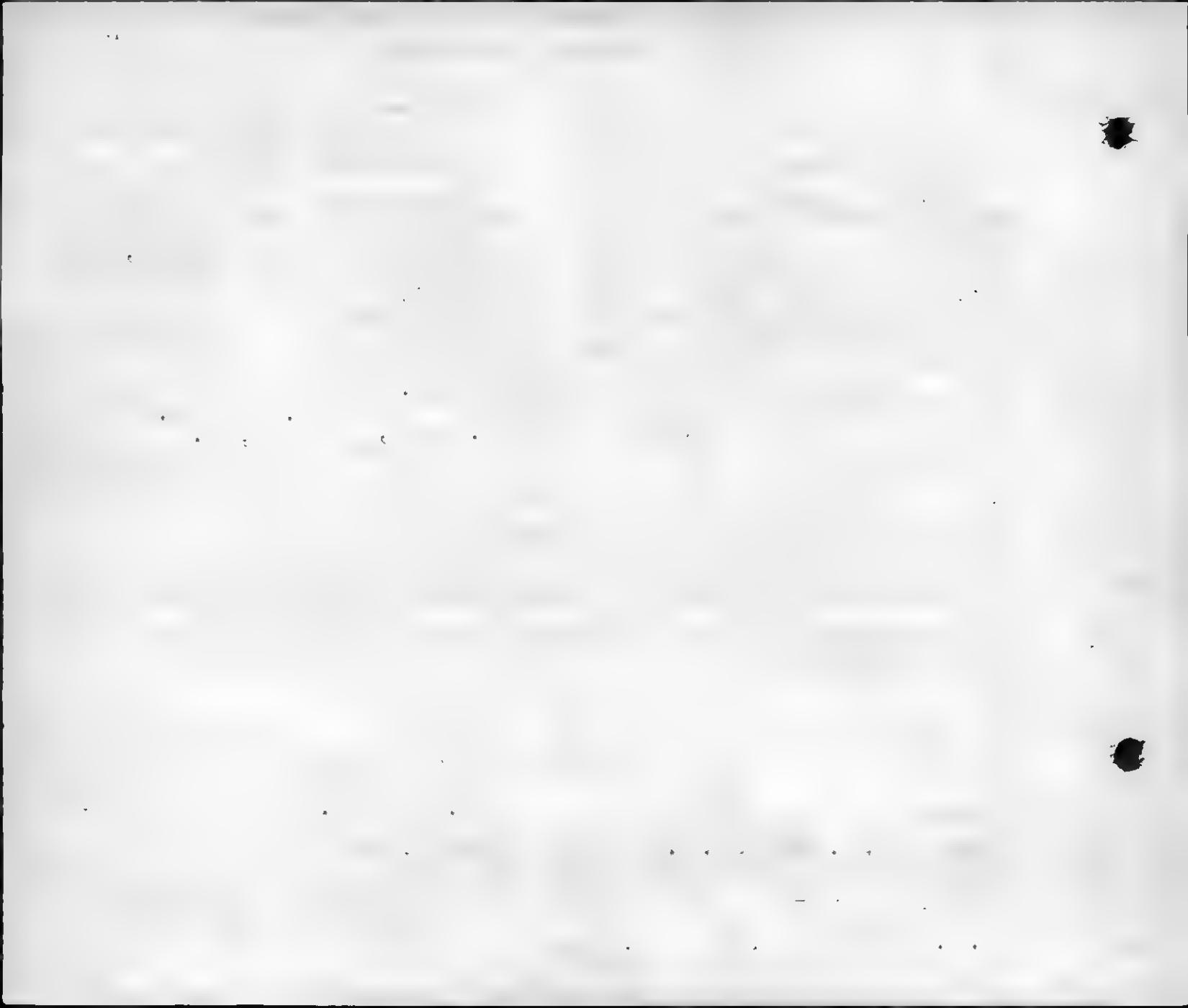
Reg. Dist. No.

05693

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>		c. LENGTH OF STAY IN 1b <b>35 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Yellow Springs</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>	
3. NAME OF DECEASED (Type or print) <b>ROGER</b>		First <b>WALLACE</b>	Middle <b>LINTON</b>
4. DATE OF DEATH <b>May 16, 1958</b>		Month <b>May</b>	Day <b>16</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4 July 1891</b>		9. AGE (In years last birthday) <b>60</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Lineman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Power Company</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Cornelius Linton</b>		14. MOTHER'S MAIDEN NAME <b>Joanna E. Harper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-4112</b>	
17. INFORMANT <b>Garmon R. Linton, Frederick, Md.</b>		313 S. Market St.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>Close</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Cardiovascular disease</b>		<b>Cardiovascular disease</b>	
(b) DUE TO <b>Cardiovascular disease</b>		<b>3 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 12, 1958</b> to <b>May 16, 1958</b> , that I last saw the deceased alive on <b>May 16, 1958</b> , and that death occurred at <b>6:45 P.M.</b> From the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>228 N. Market St., M.D.</b>	
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>5-19-58</b>	
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		Frederick, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-19-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Pleasant Hill Cemetery</b>
22d. LOCATION (Cty, town, or county) <b>Frederick County Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Deuch</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. If this certificate is detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5634

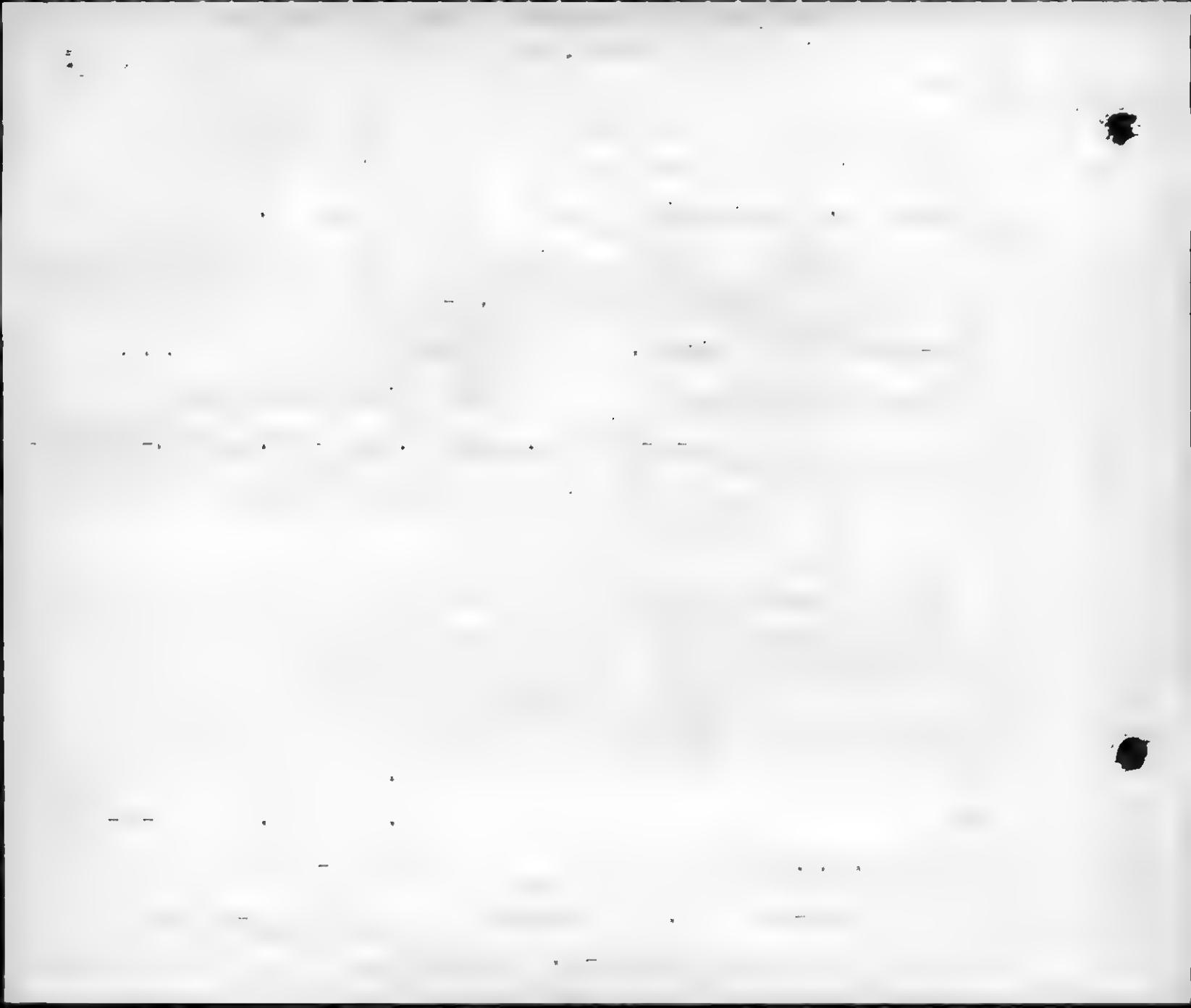
## CERTIFICATE OF DEATH

Reg. Dist. No.

05694

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Co. Chronic Hospital</b>		d. STREET ADDRESS <b>22 West South St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles</b>		First <b>Edward</b>	Middle <b>Lipps</b>	Last <b>Nov. 7-1875</b>	4. DATE OF DEATH <b>May 17th</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>82 yrs.</b>	9. AGE (In years last birthday) <b>82 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver-Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Sylvester Lipps</b>		14. MOTHER'S MAIDEN NAME <b>Martha Virginia Poffenberger</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-2280</b>		17. INFORMANT <b>Mrs. Charles E. Lipps-22 W. South St.-Frederick-</b>	Address <b>Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1600</b>		<i>Carcinoma of Nose</i>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year at work at work	20d. INJURY OCCURRED White Not white <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr 19</b> , 19 <b>58</b> , to <b>May 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 17</b> , 19 <b>58</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 N. Market St.</b> DATE SIGNED <b>5-19-1958</b>					
ACTUAL SIGNATURE <i>H.F. Kline</i>					
PHYSICIAN'S NAME (Type) <b>Dr. H.F. Kline</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-20-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Frederick-Maryland</b>		(State)			
23. FUNERAL-DIRECTOR'S SIGNATURE <i>C.E. Cline &amp; Son</i>		ADDRESS <b>Frederick-Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>C.E. Cline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDANT**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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D. J. Johnny  
Apr. 17 East 2nd St.  
Rev. 332 W College Avenue

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

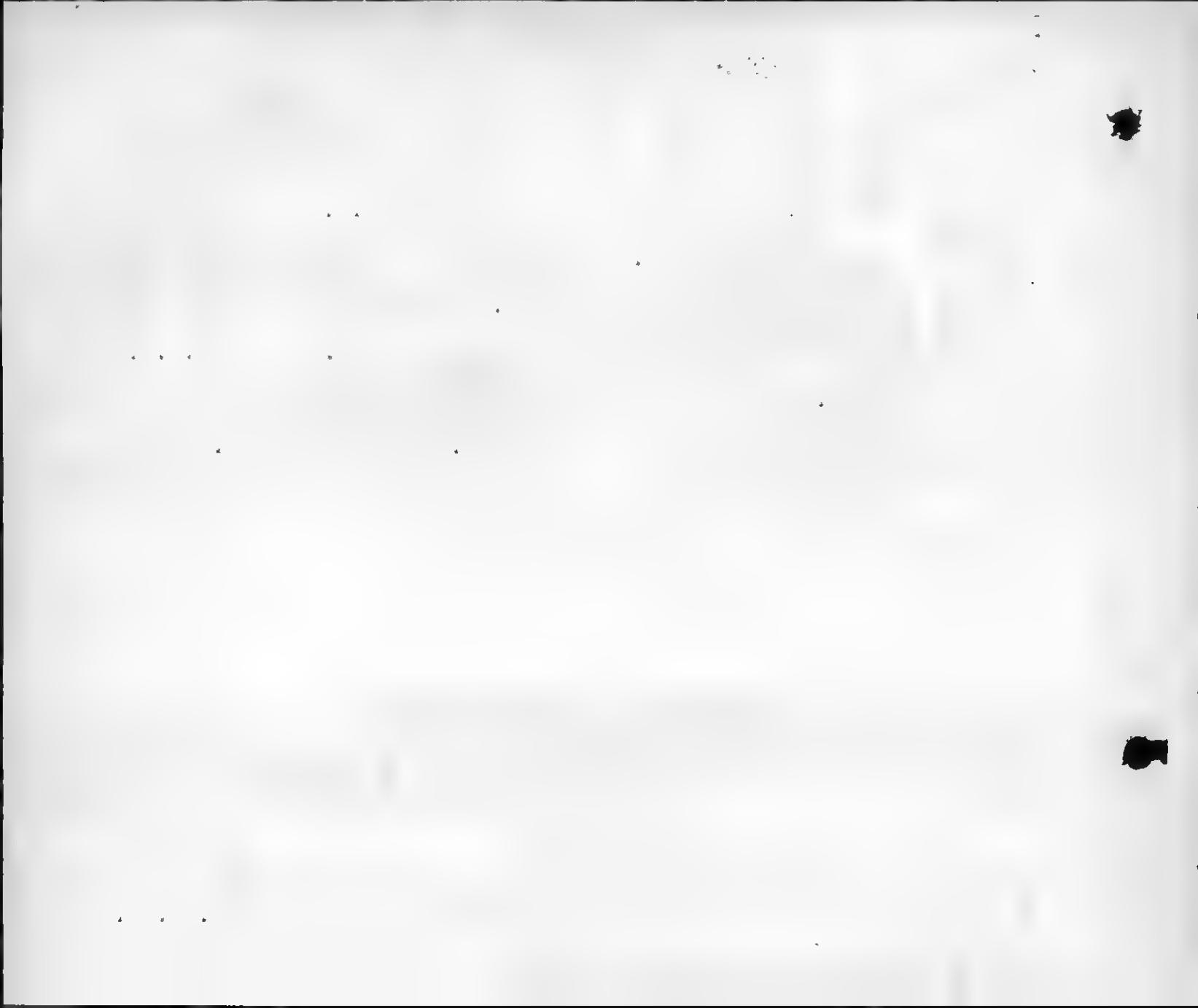
5719

## CERTIFICATE OF DEATH

05695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRADDOCK HEIGHTS</b>		c. LENGTH OF STAY IN lb <b>7 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BENEVOLA RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VINDABONA NURSING HOME</b>				d. STREET ADDRESS <b>BOONSBORO MD.R.1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CALVIN</b>		First <b>A.</b>	Middle <b>LUM</b>	Last <b></b>	4. DATE OF DEATH <b>MAY 1 1958</b>	Month <b>May</b>	Day <b>19</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 24 1879</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>TANEYTOWN MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL A. LUM</b>				14. MOTHER'S MAIDEN NAME <b>MARY MCKINSEY</b>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CALVIN A. LUM BOONSBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260 X</b> DUE TO <b>Armenia</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		(b)	<b>Amputated Rt Leg</b>		10 Days		
		(c)	<b>Diabetes Mellitus</b>		10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3</b> , 1958, to <b>May 1</b> , 1958, that I last saw the deceased alive on <b>May 1</b> , 1958, and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>Frederick Md. May 2, 1958</b>	
ACTUAL SIGNATURE <b>H. Laurence Farney</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>H. LAURENCE FAHRNEY MD</b>				FREDERICK		MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 3 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boat Fuel Home Boonsboro Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Deane</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05696

5685

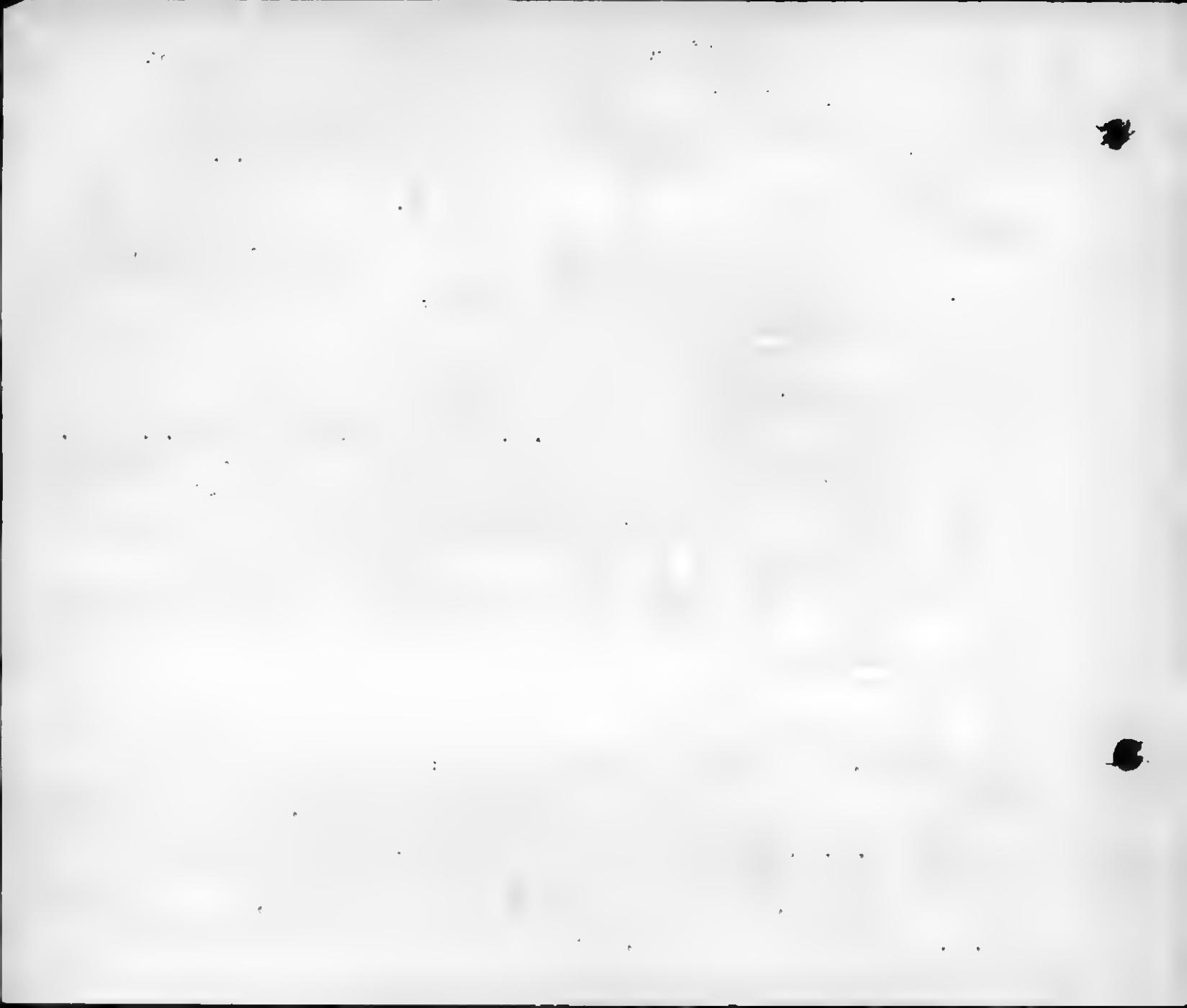
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>6 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Walkersville-Rural-R.D.#1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crutchley Nursing Home</b>		d. STREET ADDRESS <b>Near Mt. Pleasant</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ALDA</b>	Middle <b>VIRGINIA</b>	Last <b>MAIN</b>	4. DATE OF DEATH Month <b>May</b>	Day <b>7</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1884</b>	9. AGE (In years lost, birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel L. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Ann Catherine Lighter</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. P. Kieffer Main, Walkersville R.D.#1, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>							
443X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease</b>						Years	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to May 7, 1958, that I last saw the deceased alive on May 7, 1958, and that death occurred at 8:15P M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>East Church Street,</b>	
ACTUAL SIGNATURE <b>H. J. Slusher</b>						DATE SIGNED <b>5/9/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H. J. Slusher</b>		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick,</b>	
						(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 12 '58		24b. REGISTRAR'S SIGNATURE <b>Reed</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0569?

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5686	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
Frederick		MARYLAND	a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	b. COUNTY	Frederick
Frederick		33 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Rear-Hillside Coal Co.— Water Street		12 Wisner Street		

3. NAME OF DECEASED (Type or print)	First Mitchell	Middle Lee	Last Mansfield	4. DATE OF DEATH	Month May	Day 31	Year 19 58
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5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
Male	White	WEDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/>	May 25-1905	53 yrs.	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
勞工 (Laborer)		West Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mewton Mansfield	Flora A. Luttrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	219-07-9509	Frank Mansfield- Frederick-Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3220</u> DUE TO <u>Acute Cardiac congestion</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u>	
DUE TO (c) <u>Acute Alcoholism</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)

21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <u>B.O.Thomas</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>6/2/58</u>
EXAMINER'S NAME (Type) <u>B.O.Thomas</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF June 3-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick-Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E.Cline &amp; Son</u>		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE JUN 3 '58
			24b. REGISTRAR'S SIGNATURE <u>Allie Smith</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5720

## CERTIFICATE OF DEATH

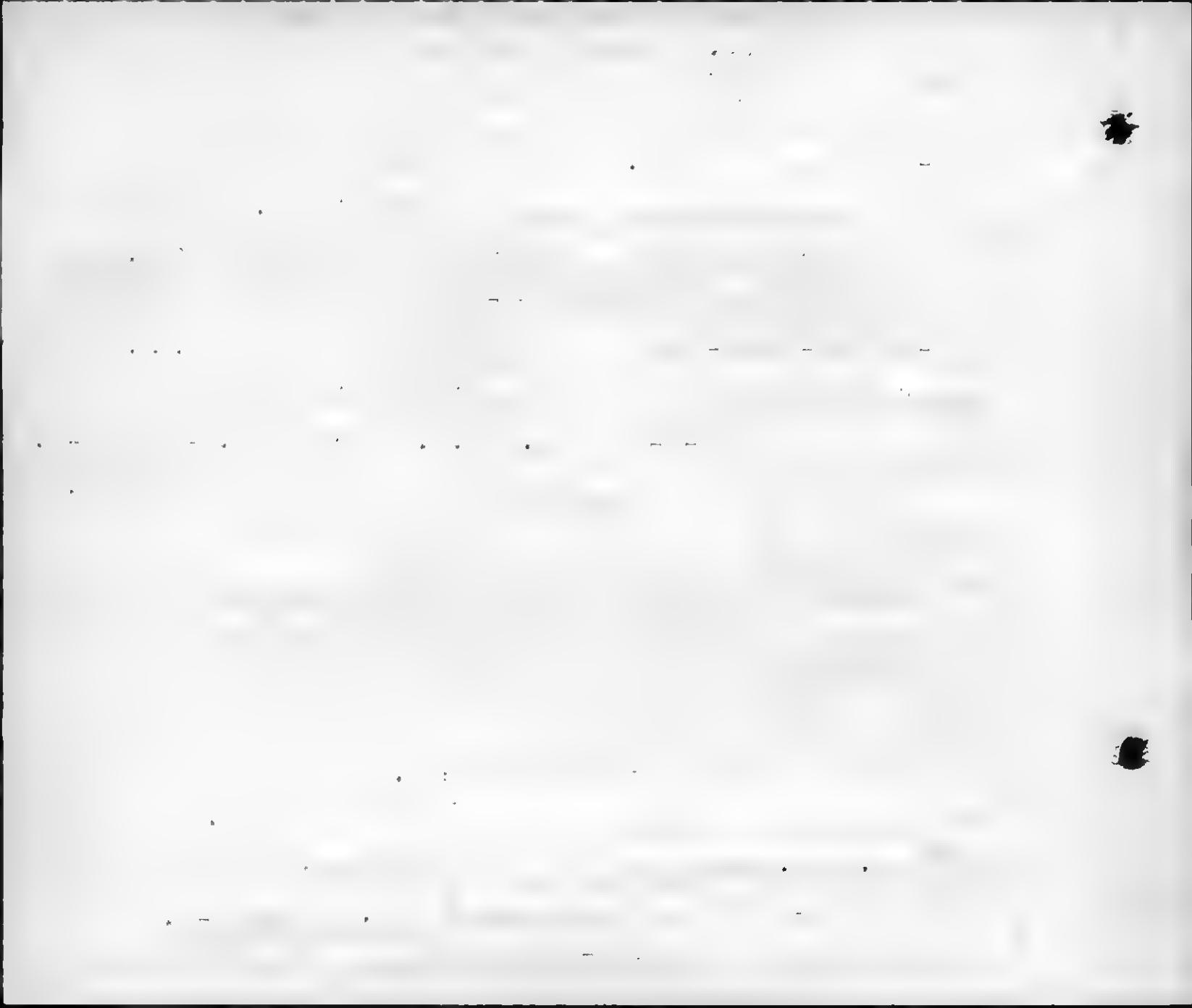
Reg. Dist. No.

05698

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Frederick</b>		c. LENGTH OF STAY IN 1b <b>6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>108 East Fifth St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 5</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b>Henry</b>	Last <b>Masser</b>	4. DATE OF DEATH <b>May 21st.</b>	Month <b>May</b>	Day <b>21st.</b>	Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>9-9-1873</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Carpenter-Builder- Homes</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frederick Masser</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Klipp</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-18-8231</b>		17. INFORMANT <b>Mrs. Chas. H. Masser (Wife) Rt. 5-Frederick-Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1174X</b>		DUE TO <i>Sensitivity</i>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO								
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>July</b>	Day <b>19 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>35 East Church St.</b>	(County) <b>Frederick, Maryland</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>July 19 58</b> to <b>May 21 1958</b> , that I last saw the deceased alive on <b>May 20 1958</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>35 East Church St.</b>
ACTUAL SIGNATURE <i>Rex R. Martin</i>	PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>		M.D.					DATE SIGNED <b>5-22-58</b>
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 24-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rocky Springs Cemetery</b>	22d. LOCATION (City, town, or county) <b>W. of Frederick, Md.</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline &amp; Son</i>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D. BY REGISTRAR <b>MAY 20 58</b>	24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



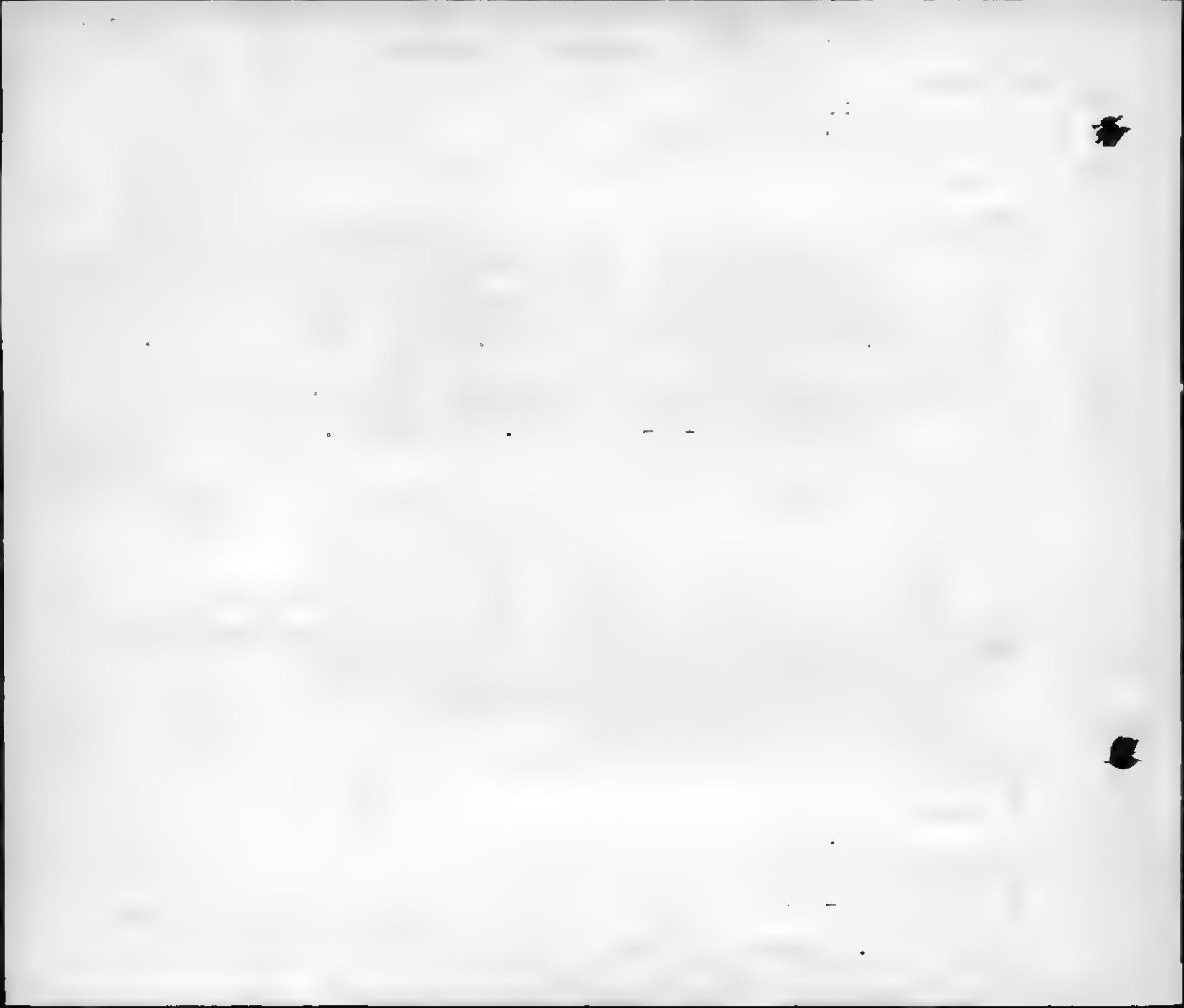
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5721 CERTIFICATE OF DEATH**

05699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)	
				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cullen		50 yrs.		X Cullen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		James	Arthur	McKissick	May 17
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 29, 1897	60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Maintenance Man		Victor Cullen Hosp.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Sheridan McKissick		Catherine E. McClain		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes no or unknown)</small>		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		419-36-4922		Mrs. Catherine W. McKissick Sabillasvill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Causes of death 156.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO			
{		DUE TO			
{		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Date 5-20-58 to May 17, 1958, that I last saw the deceased alive on May 17, 1958, and that death occurred at 8:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL MEDIUM		M.D. Robert A. Kiefer			
PHYSICIAN'S NAME (Type)		DATE SIGNED May 18, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE MAY 22 '58	
Raymond E. Creager				24b. REGISTRAR'S SIGNATURE A. L. Smith	

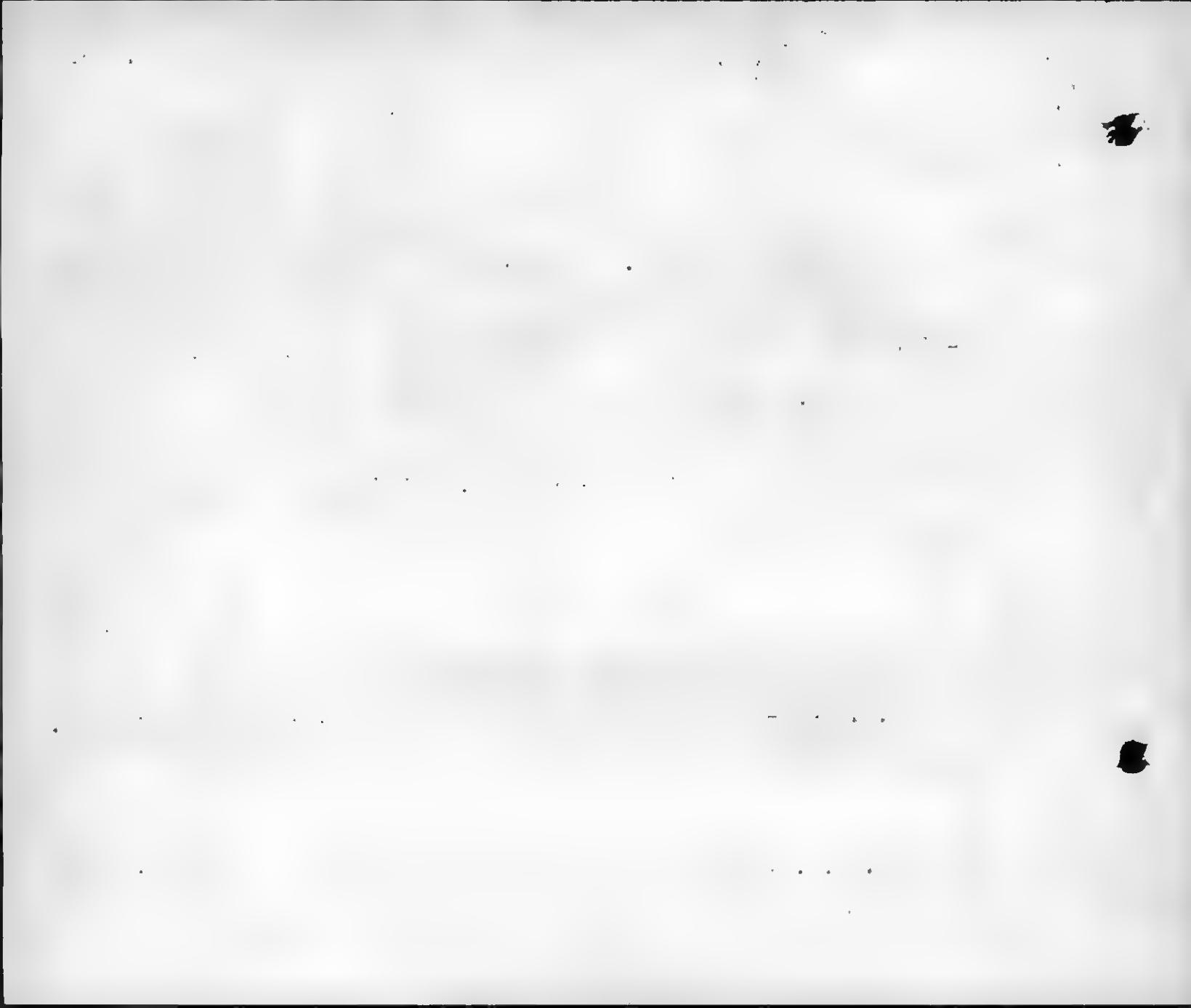
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician. It should be retained by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO DEPUTY MEDICAL EXAMINER:** This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										5722	05700		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Items 2, 7, 11, 12, 13, 14, 15 File G229 5-29-58 et Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Illinois		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - Brunswick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Markham		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2834 Stafford Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Paul		Middle F.		Last Meyer		4. DATE OF DEATH		Month May	Day 20	Year 19 58	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years by birthday) 26 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hour Min.	
Male		White											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co-pilot</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Paul E. Meyer						14. MOTHER'S MAIDEN NAME Freda (Last name not given)			Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b>										INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>											
20c. TIME OF INJURY 11:45 a.m. 5-20-58 p.m.		Month Day Year 5-20-58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air		20f. (City or town) Rural		(County) (State) Frederick Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>B.H. Thomas</i>		DATE SIGNED May 20, 1958											
EXAMINER'S NAME (Type) Dr. H.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Edwin H. Funeral Home		22d. LOCATION (City, town, or county) Somerton, Pa.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE B. La Festa		ADDRESS Brunswick Md.		24a. REC'D BY REGISTRAR MAY 26 '58		24b. REGISTRAR'S SIGNATURE A. Leesman							
VS. A15ME(5) 5M 9/55													



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05701

Reg. Dist. No.

Items 2, 7, 8, 9, 10a, 11, 13, 14, 15 Film G229 6-2-58 et

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		5723 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Massapequa, L. I.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Massapequa, L. I.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>95 Hampton Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Thomas</b>	Middle <b>Henry</b>	Last <b>Morgan</b>	4. DATE OF DEATH Month <b>May</b> Day <b>20</b>	Year <b>1958</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 2, 1921</b>	9. AGE (In years last birthday) <b>36 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Life Ins. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13. FATHER'S NAME <b>Thomas Jones Morgan</b>	14. MOTHER'S MAIDEN NAME <b>Emily Minner</b>	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b>		INTERVAL BETWEEN ONSET AND DEATH
861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRINCIPAL <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (See note of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>				
20c. TIME OF INJURY Hour <b>11:45 p.m.</b>	Month, Day, Year <b>5-20-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	20f. (City or town) <b>Rural Frederick Md.</b>	(County) <b>Frederick</b> (State) <b>Md.</b>

21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
---	--	--	--	--	--

ACTUAL SIGNATURE <i>B.O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <b>May 20, 1958</b>
NAME (Type) <b>Dr. B.O. Thomas</b>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/27/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Pineyawn Cem. Massapequa Funeral Home</b>	22d. LOCATION (City, town, or county) <b>Long Island</b> (State) <b>Long Island</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Feit</i>	ADDRESS <b>Brunswick Md</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Deborah</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

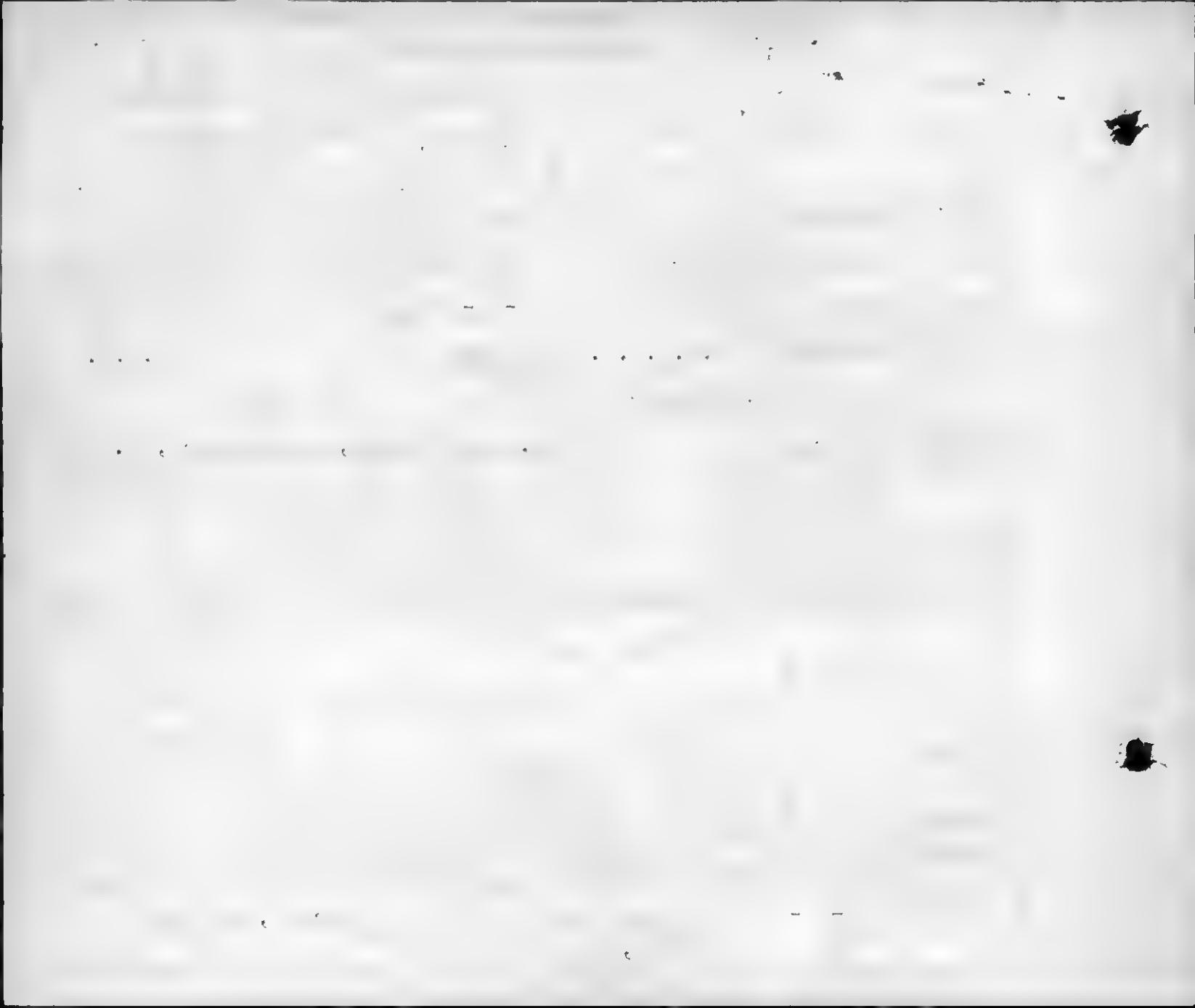
## 5687 CERTIFICATE OF DEATH

05702

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN lb 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS 710 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>Joseph</b>		First <b>Kalen</b>	Middle <b>M</b>	Last <b>MUSSER</b>	4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>12-22-1883</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O.R.R.Co</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
13. FATHER'S NAME <b>Peter Abrham Musser</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Spanish American</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Maury Thorpe, Falls Church, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>BILATERAL BRONCHOPNEUMONIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CONGESTIVE FAILURE</b> (b) DUE TO <b>ARTERIO-SCLEROTIC HEART DISEASE</b> ? (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 MAY</b> , 1958, to <b>24 MAY</b> , 1958, that I last saw the deceased alive on <b>24 MAY</b> , 1958, and that death occurred at <b>107</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. PROFESSIONAL BLDG., DATE SIGNED <b>5/29/58</b> PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR.</b> ADDRESS <b>FREDERICK, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-26-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>River View</b>	
22d. LOCATION (City, town, or county) <b>Hancock, Maryland</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feste</b>		ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quinton</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5688 CERTIFICATE OF DEATH**

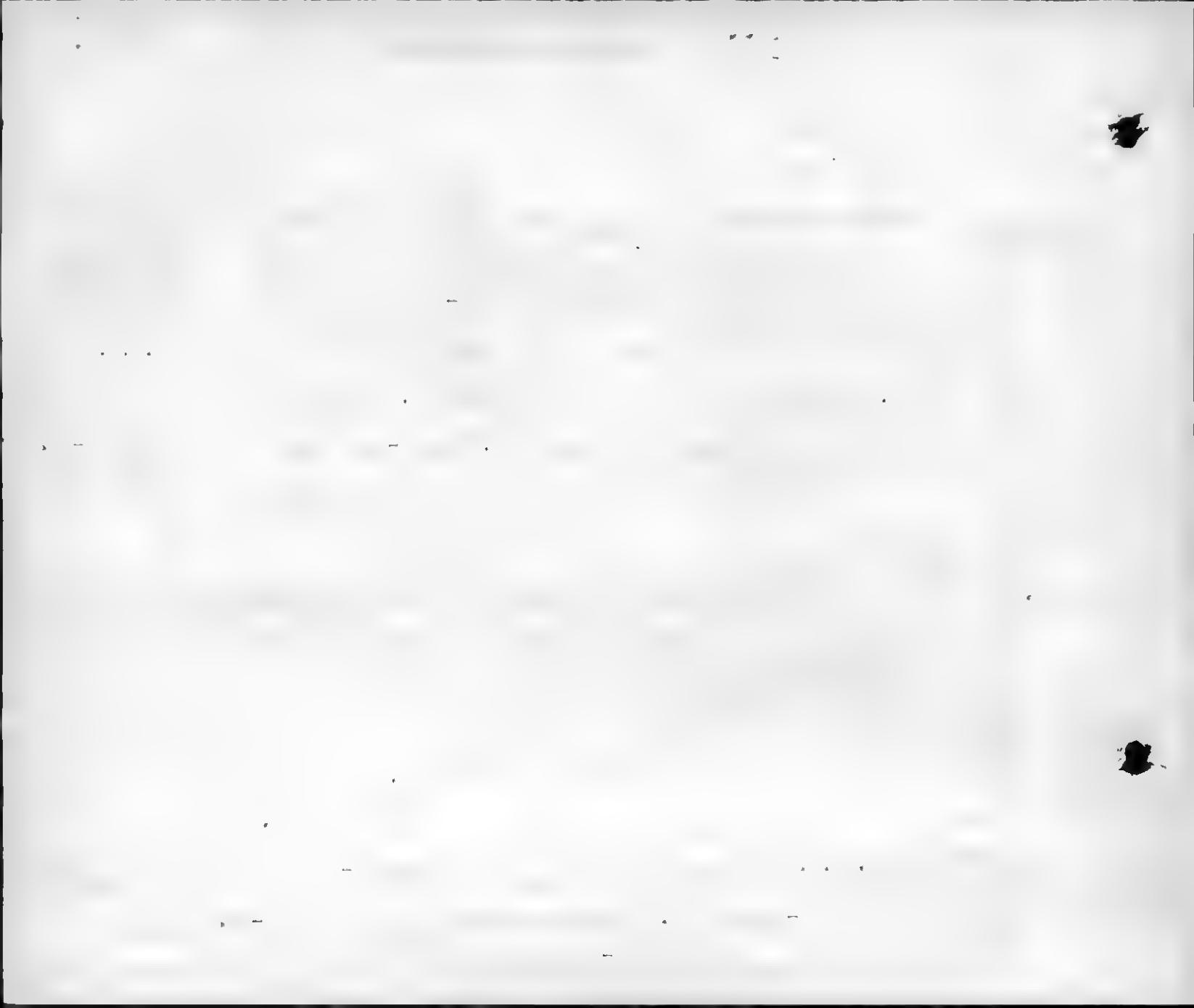
05703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 West Fifth Street</b>				d. STREET ADDRESS <b>123 West Fifth Street</b>			
3. NAME OF DECEASED (Type or print) <b>Annie Naomi Nikirk</b>		First	Middle	Last	4. DATE OF DEATH Month <b>May</b>	Day <b>26th</b>	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRITAL STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>July 29-1892</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank A. Sheffield</b>				14. MOTHER'S MAIDEN NAME <b>Annie C. Welty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edwin F. Nikirk-910 Motter Place-Frederick-Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Paroxysma of Lung</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>6 mo</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1, 1958</i> to <i>May 26, 1958</i> , that I last saw the deceased alive on <i>May 25, 1958</i> , and that death occurred at <i>11:15A.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>4 East Church St.</i> DATE SIGNED							
ACTUAL SIGNATURE <i>E.P. Thomas</i> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. E.P. Thomas</b>		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline &amp; Son</i>		ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Oleksuk</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5689

Item 12 Film 7230 6-16-58 et  
CERTIFICATE OF DEATH

05704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY Frederick	
Frederick	60 p.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Visitation Convent	11 East 2 <sup>nd</sup> St		
3. NAME OF DECEASED (Type or print)	First BRIDGET	Middle —	4. DATE OF DEATH
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 22 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Keligious Nun		Ireland	Ireland
13. FATHER'S NAME James O'Donnell	14. MOTHER'S MAIDEN NAME Bridget Gallagher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Records of Visitation Frederick Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left hip			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 15, 1958 to May 4, 1958 that I last saw the deceased alive on May 3, 1958, and that death occurred at 5:55 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V Chase	M.D.	ADDRESS (Street, city or town, state) 41 Church St	DATE SIGNED 5/5/58
PRINTED NAME (Type) Henry V. Chase	Frederick Md		
22a. BURIAL, CREMATION / REMOVAL (Specify) Burial May 5 1958	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL Visitation	22d. LOCATION (City, town, or county) Frederick Frederick Md
23. FUNERAL DIRECTOR'S SIGNATURE Clarence C. Tandy	ADDRESS	24a. REC'D BY REGISTRAR MAY 16 '58	24b. REGISTRAR'S SIGNATURE Albert E. Johnson

HOSPITAL OR ATTENDING PHYSICIAN: Title law requires that the death certificate be executed within 24 hours after death. Page 1  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 3

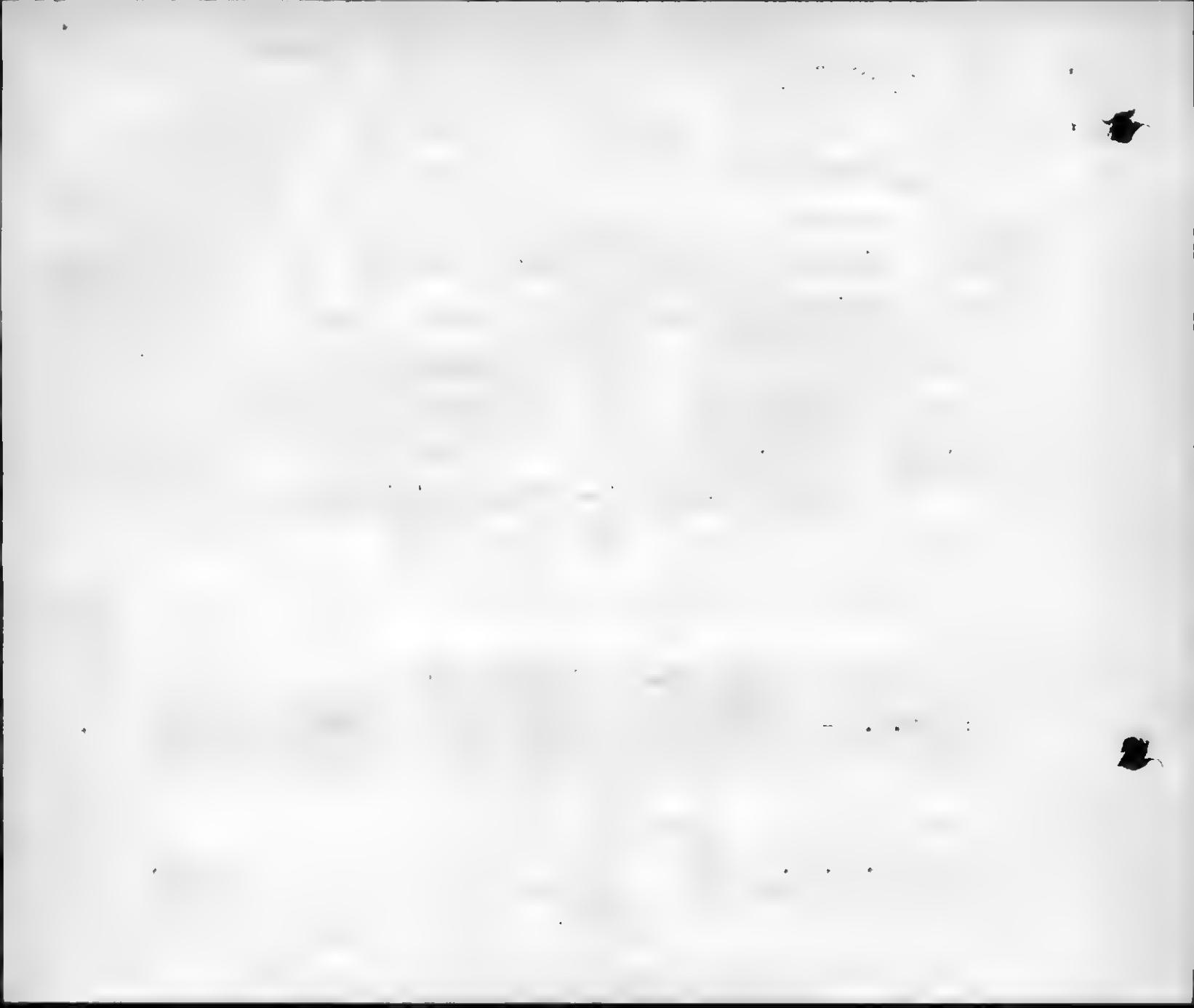
## 5724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05705

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Illinois		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Chicago 8		51		d. STREET ADDRESS	
Rural Brunswick				Chicago 8		1248 West 23rd Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Nick		Thomas	Oleferchik		May	20	19	58			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years to last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		21 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Chicago, Illinois			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Nick Oleferchik			Mollie Rutkowski								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
C. G. Reserve (6 Mos. Service)						Zefram Funeral Home, Chicago, Ill.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures and injuries</u> INTERVAL BETWEEN ONSET AND DEATH											
861X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Airplanes collided in air</u>									
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
11:45 p.m. 5-20 '58		Air				Rural Frederick		Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>B. O. Thomas</u>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 20, 1958									
EXAMINER'S NAME (Type) Dr. B. O. Thomas											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE OF DEATH <u>5/21/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Zefran Funeral Home</u>		22d. LOCATION (City, town, or county) <u>Chicago</u>		(State) <u>Ill.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Teete</u>		ADDRESS <u>Brunswick Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Altman</u>					

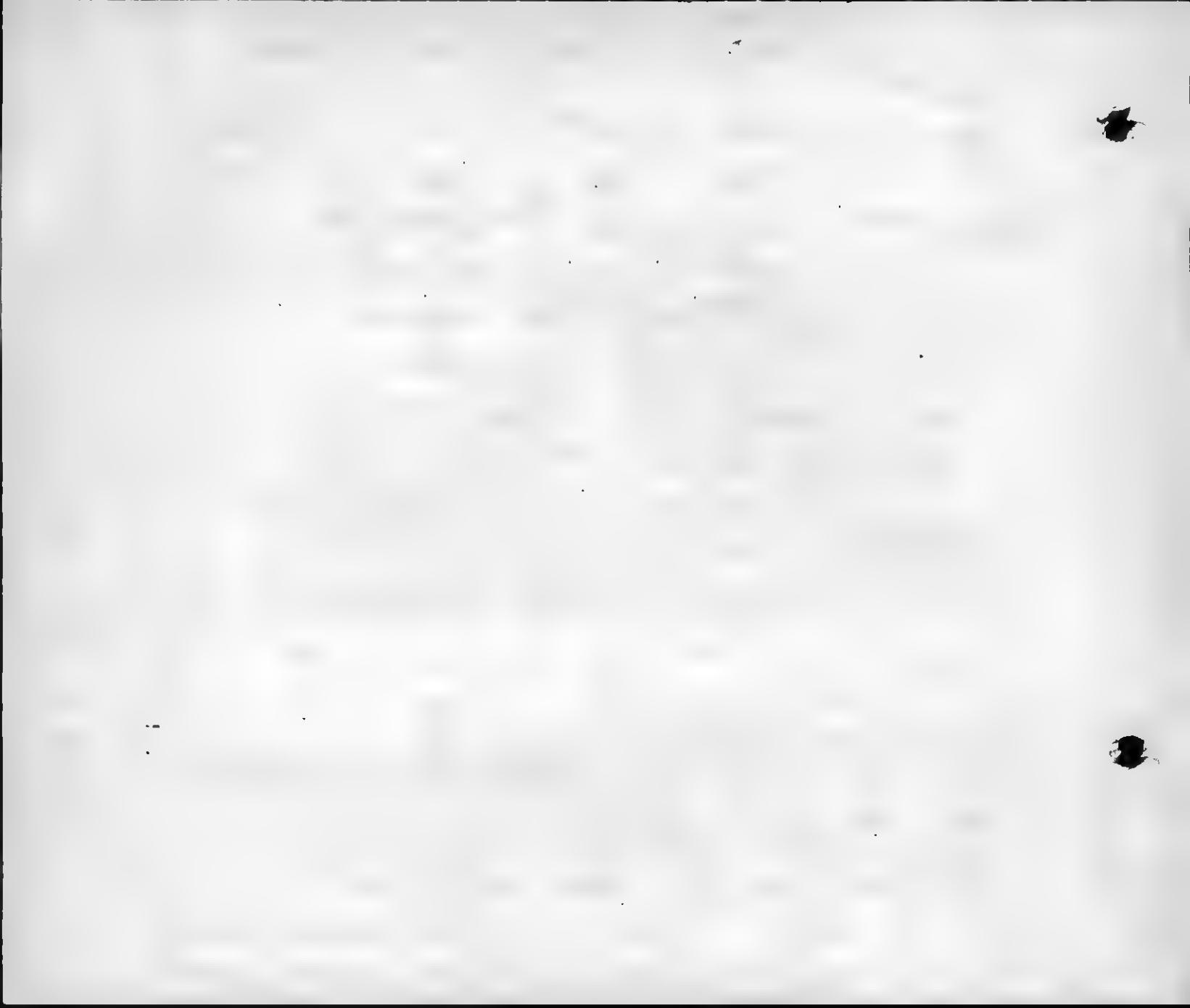


**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 05706
Item 9 FilmG229 6-2-58 st										
1. PLACE OF DEATH a. COUNTY <i>Frederick</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>							
MARYLAND			b. COUNTY <i>Frederick</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i>			c. LENGTH OF STAY IN 1b <i>22 yrs</i>							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i>			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ELM ST.</i>			e. STREET ADDRESS <i>Elm Street</i>							
3. NAME OF DECEASED (Type or print)			First <i>Walter</i>	Middle <i>Carol</i>	Last <i>Ramsey</i>	4. DATE OF DEATH <i>May 23 1958</i>	Month <i>May</i>	Day <i>23</i>	Year <i>1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 25, 1901</i>		9. AGE (In years at birthday) <i>57</i>	10. IF UNDER 1YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>11</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hunter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				
13. FATHER'S NAME <i>George Washington Cramer</i>		14. MOTHER'S MAIDEN NAME <i>Mollie C. Cramer</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-8745</i>		17. INFORMANT <i>Glen Ramsey</i>		Address <i>Thurmont, Md</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot in road left chest</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>gun shot in road left chest</i>										
DUE TO (c) <i>gun shot in road left chest</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self inflicted gun shot in road left chest</i>								
20c. TIME OF INJURY Month, Day, Year Hour p. m. <i>5/23 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Frederick</i>		(County) <i>Frederick</i>		(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>B.C. Thomas</i>		DATE SIGNED <i>May 23-1958</i>								
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>May 26, 58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>UTICA</i>		22d. LOCATION (City, town, or county) <i>Frederick Co</i>		(State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Geiger Thurmont, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>May 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arleach</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

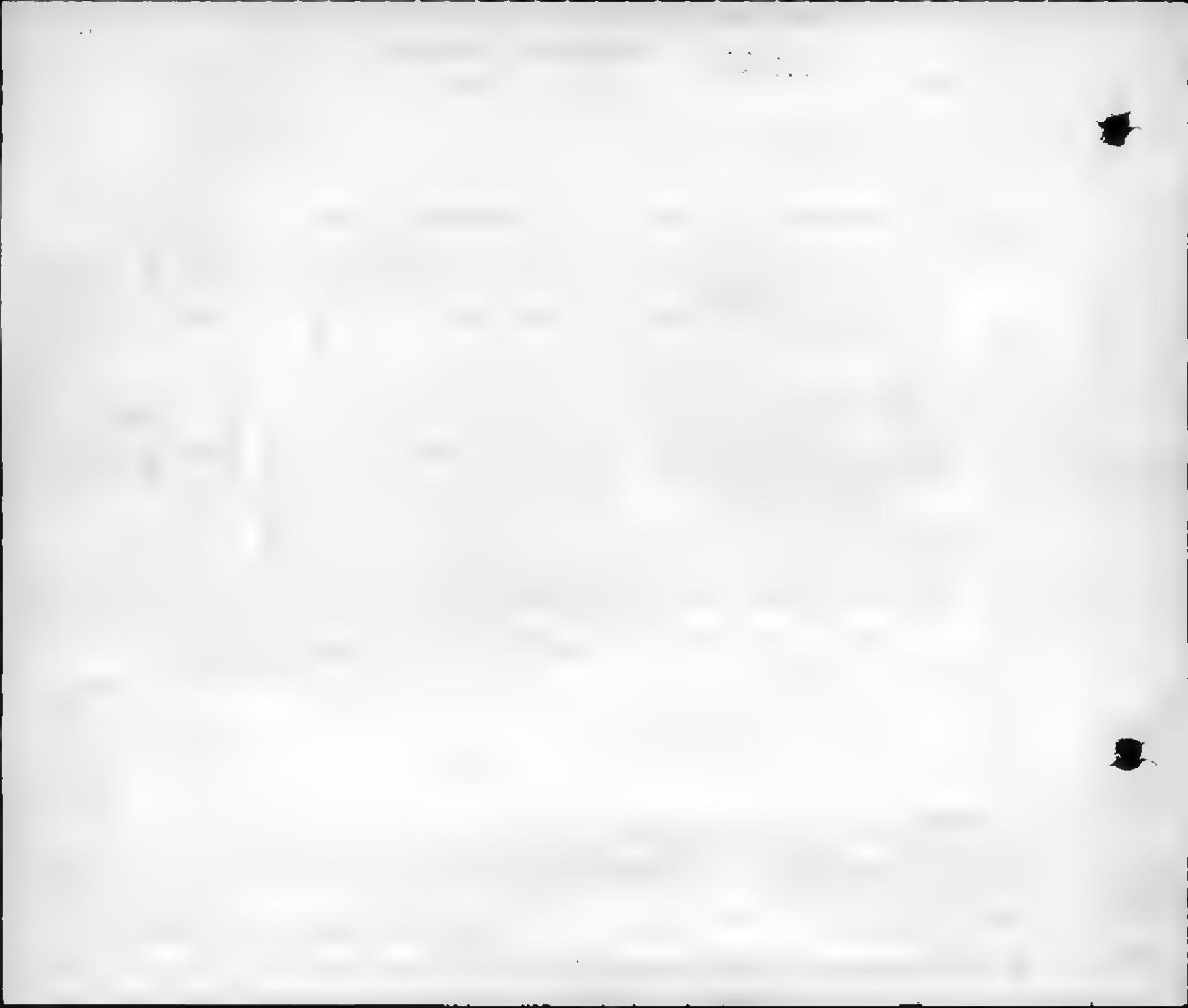
5726

## CERTIFICATE OF DEATH

Reg. Dist. No.

05707

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO RURAL</b>	c. LENGTH OF STAY IN TB <b>YEARS</b>	b. COUNTY <b>FREDERICK</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO RURAL</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>ROSCOE L.</b>	Middle <b>RIPPEON</b>	4. DATE OF DEATH Last <b>MAY 2 1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21-1880</b>
9. AGE (In years, lost birthday) <b>78 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>BRADLEY T RIPPEON</b>	14. MOTHER'S MAIDEN NAME <b>MARTHA FRITZ</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>215-36-8623</b>	17. INFORMANT <b>ANNIE S RIPPEAN</b>	Address <b>RURAL WOODSBORO MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 2 1958</b> to <b>May 3 1958</b> that I last saw the deceased alive on <b>May 2 1958</b> and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LIBERTYTOWN MD</b> DATE SIGNED <b>May 6 1958</b>			
ACTUAL SIGNATURE <b>J. H. MESSLER, M.D.</b>	PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MAY 6-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>UNION CHAPEL</b>	22d. LOCATION (City, town, or county) (State) <b>LIBERTYTOWN MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hartzer Sons Libertytown Md</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>MAY 6 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Deborah</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05708

5727

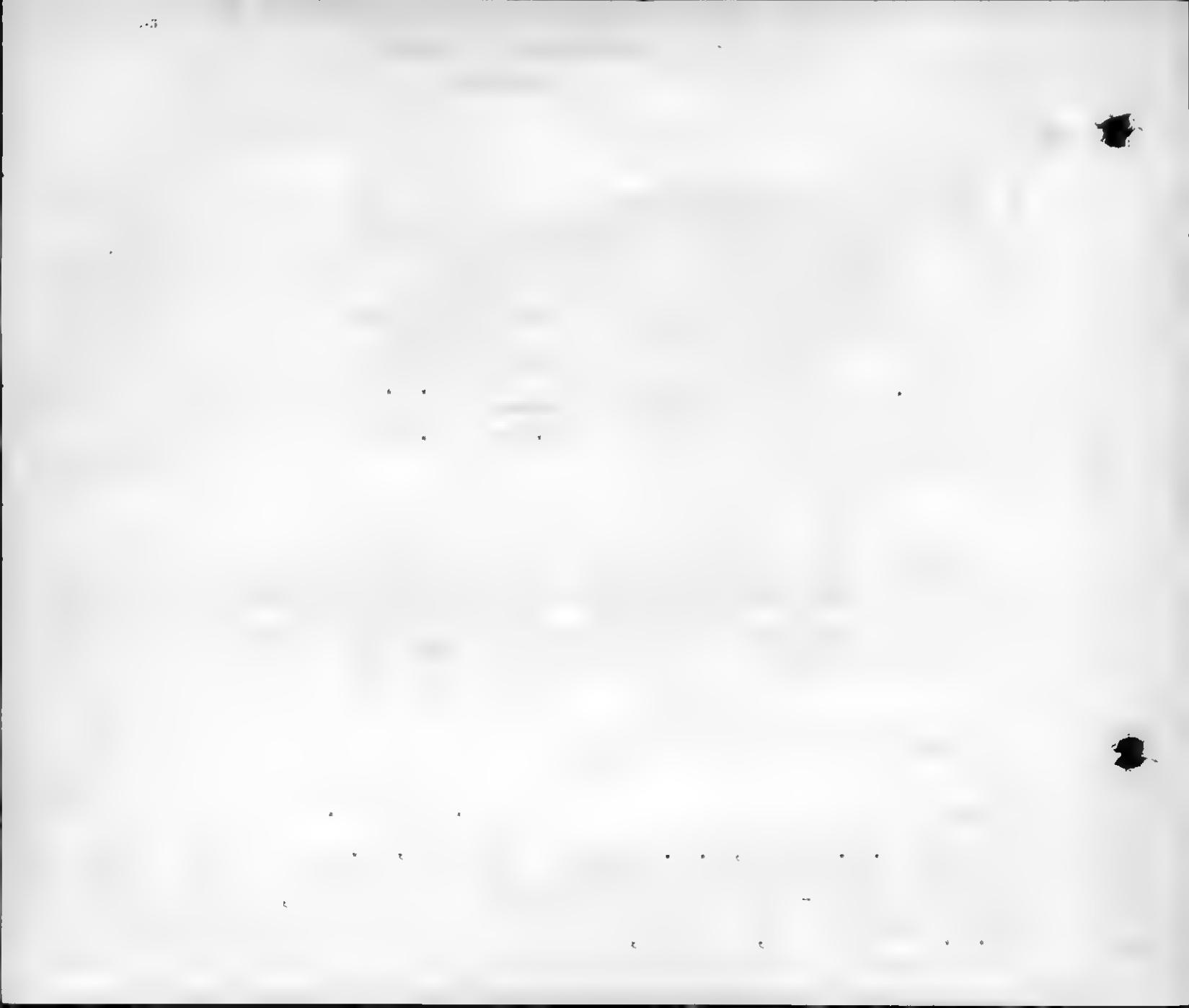
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN lb 3 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home		e. STREET ADDRESS 1003 Rosemont Avenue	
3. NAME OF DECEASED (Also Known As Stella Burkhardt Sanner) (Type or print) Estella Lena Burkhardt Sanner		4. DATE OF DEATH Month Day Year May 27, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 May 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Staley		14. MOTHER'S MAIDEN NAME Clara A. C. (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Staley V. Sanner (Same as Item #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Central Hemorrhage 3 Days Cardio-Vascular Renal Disease 10 years Senility	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1955, to May 27, 1958, that I last saw the deceased alive on May 27, 1958, and that death occurred at 3 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE H. L. Fahrney, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 17 E. Second St. 28 May 1958	
PHYSICIAN'S NAME (Type) H. L. Fahrney, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-58	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JUN 2 '58	24b. REGISTRAR'S SIGNATURE Al. Leach



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5728

## CERTIFICATE OF DEATH

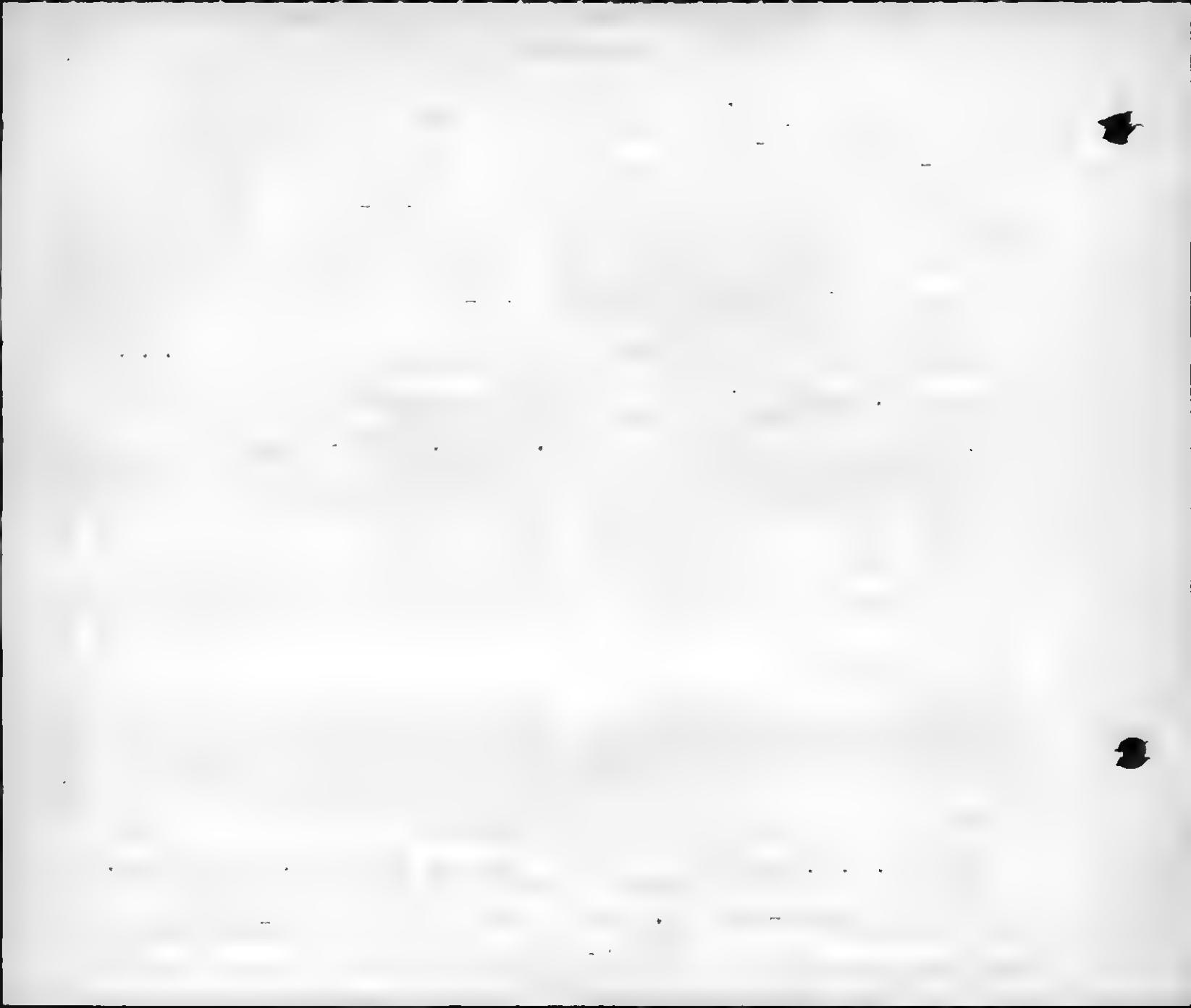
05709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]							
Frederick MARYLAND		a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY Frederick							
Rural-Praddock Heights	9 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS							
Vindobona Convalescent Home									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Ossie	Middle Anna	Last Shankle	4. DATE OF DEATH	Month May	Day 7	Year 19 58	
S. SEX		6. COLOR OR RACE	7. MARRIED	B. DATE OF BIRTH	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS		
Female		White	<input checked="" type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> F	9-12-1883	Months	Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		Virginia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Nelson B. Ponton		Mary Grant							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		None		Mr. Harry D. Shankle-Buckeystown					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>acute Cardiac Dilatation</i>					3 min		
44dx		DUE TO		<i>Cerebral Hemorrhage</i>			3 month		
Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		DUE TO		<i>Cardio Vascular Renal Disease</i>			unknown		
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<i>Vertebral Arteria</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from <u>March 31, 1958</u> , to <u>May 7 - 1958</u> , that I last saw the deceased alive on <u>May 7, 1958</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. L. Fahrney</u>								ADDRESS (Street, city or town, state) <u>17 East 2nd Street, Frederick, Md.</u>	
								DATE SIGNED <u>17 East 2nd Street, Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 10-1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Frederick, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E.Cline &amp; Son</u>		ADDRESS <u>Frederick-Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Nease</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **Q5710**

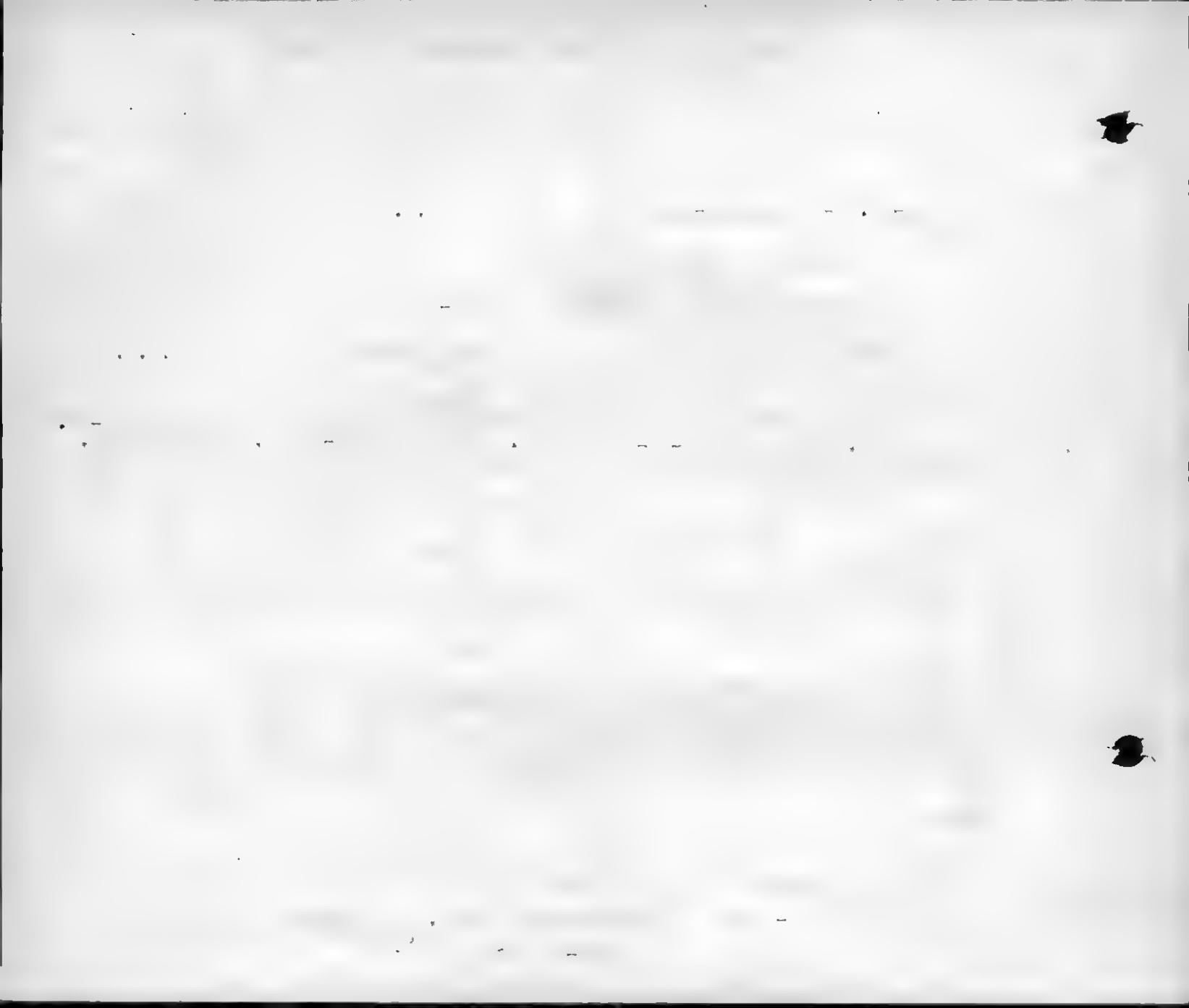
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File Pages 1 and 2 with the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN lb <b>Highway-Rt.15- Frederick- (North)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Highway-Rt.15- Frederick- (North)</b>			e. STREET ADDRESS <b>P.O. Adamstown</b>		
3. NAME OF DECEASED (Type or print) <b>William LeRoy Smith</b>			f. DATE DEATH <b>May 10 1958</b>		
g. SEX <b>Male</b>		h. COLOR OR RACE <b>White</b>		i. DATE OF BIRTH <b>July 4-1915</b>	
j. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		j. 10b. KIND OF BUSINESS OR INDUSTRY		k. 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
l. FATHER'S NAME <b>John Smith</b>			m. 14. MOTHER'S MAIDEN NAME <b>Violet Fair</b>		
n. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>Yes W.War II</b>			o. 16. SOCIAL SECURITY NO. <b>205-09-4016</b>		
p. 17. INFORMANT <b>Mrs. Ruth Hoke Fair-399 S. Washington St.</b>			q. Address <b>Greencastle-Pa.</b>		
r. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture base of skull</b> DUE TO <b>Conditions, if any, which gave rise to immediate cause</b> (b) <b>Fracture left thigh</b> DUE TO <b>Crushed chest</b> (c)			s. INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
t. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
u. 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			v. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <b>Automobile ran into a tree</b>		
w. 20c. TIME OF INJURY Month, Day, Year <b>1:20 p.m. 5/10 1958</b>			x. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
y. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 15</b>			z. 20f. (City or town) <b>Hanover Frederick</b> (County) <b>Baltimore</b> (State) <b>Md.</b>		
aa. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
bb. ACTUAL SIGNATURE <b>B. Thomas</b>			cc. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
dd. EXAMINER'S NAME (Type) <b>B. O. Hoke</b>			ee. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
ff. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			gg. DATE SIGNED <b>5/12/58</b>		
hh. 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		ii. 22b. DATE THEREOF <b>May 14-1958</b>		jj. 22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cem.</b>	
kk. 23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>		ll. ADDRESS <b>Frederick-Maryland</b>		mm. 24a. REC'D DATE SIGNATURE <b>5/12/58</b>	
nn. DATE <b>SM 2/57</b>				oo. 24b. REGISTRAR'S SIGNATURE <b>W. Cline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05711

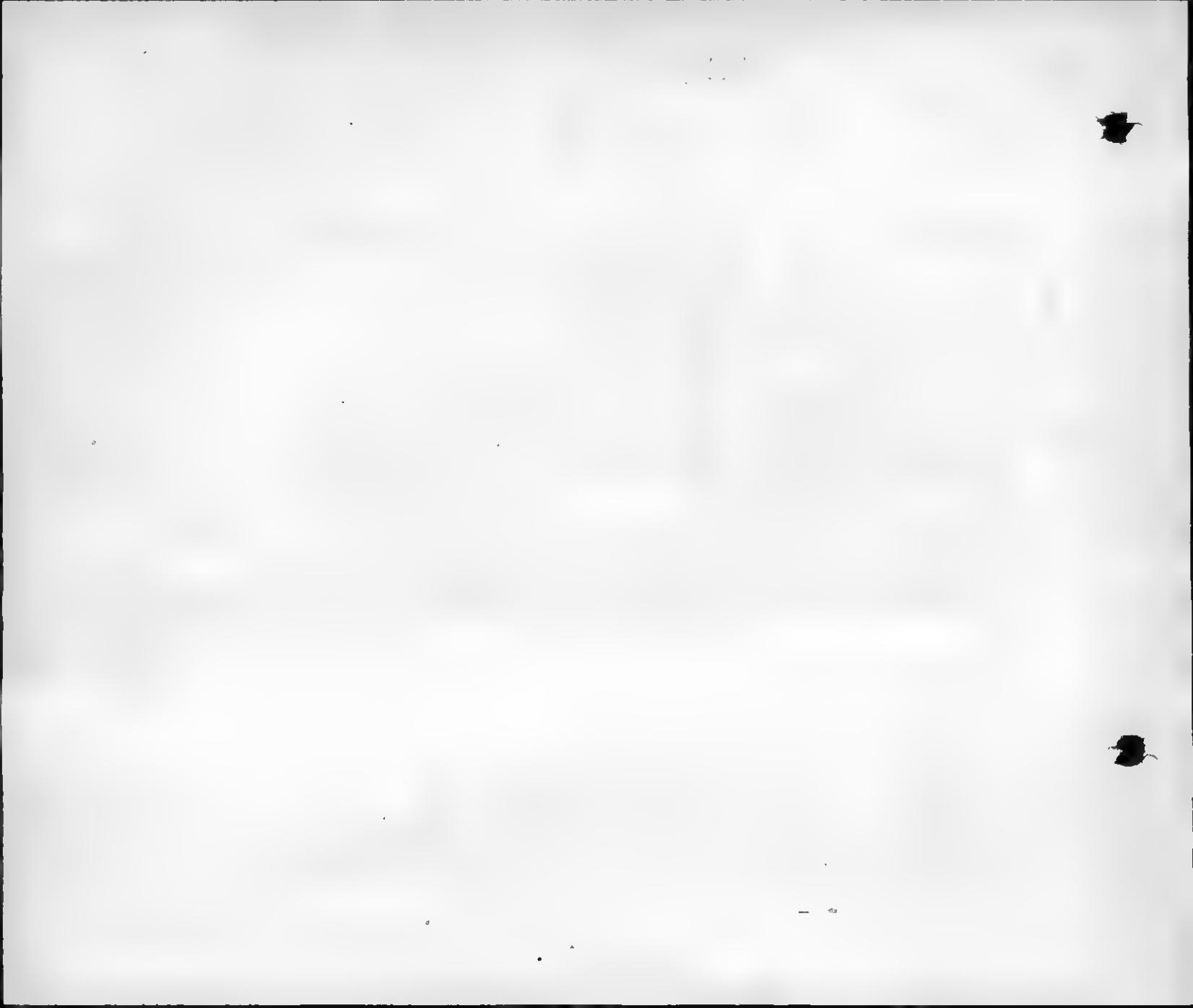
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Craigestown</i>		c. LENGTH OF STAY IN 1b <i>50 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Craigestown</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS							
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>Carrie</i>	Middle <i>May</i>	Last <i>Spears</i>	DATE OF DEATH <i>May. 29</i>						
4. MONTH <i>Month</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
8. DATE <i>Year</i>		9. AGE in years (last birthday) <i>72 yrs</i>		10. IF UNDER 1 YEAR Months <i>Days</i> Hours <i>Min.</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>							
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>											
13. FATHER'S NAME <i>John Valentine</i>		14. MOTHER'S MAIDEN NAME <i>Laura V Creager</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>							
				16. SOCIAL SECURITY NO <i>220-16-0562</i>							
17. INFORMANT <i>Mrs. Milton Grimes</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		Address <i>Thurmont, Md.</i>							
		19. INTERVAL BETWEEN ONSET AND DEATH <i>months</i>									
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>B. P. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>May 29, 1958</i>	
EXAMINER'S NAME (Type) <i>B. P. Thomas</i>		22b. DATE THEREOF <i>6-1-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>United Prethern Corp.</i>		22d. LOCATION (City, town, or county) <i>Thurmont, Maryland</i>					
22a. BURIAL CREMATION REMOVAL (Specify) <i>Funeral</i>		24a. REC'D BY REGISTRAR <i>JUN 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Creager</i>		ADDRESS <i>Thurmont, Md.</i>									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

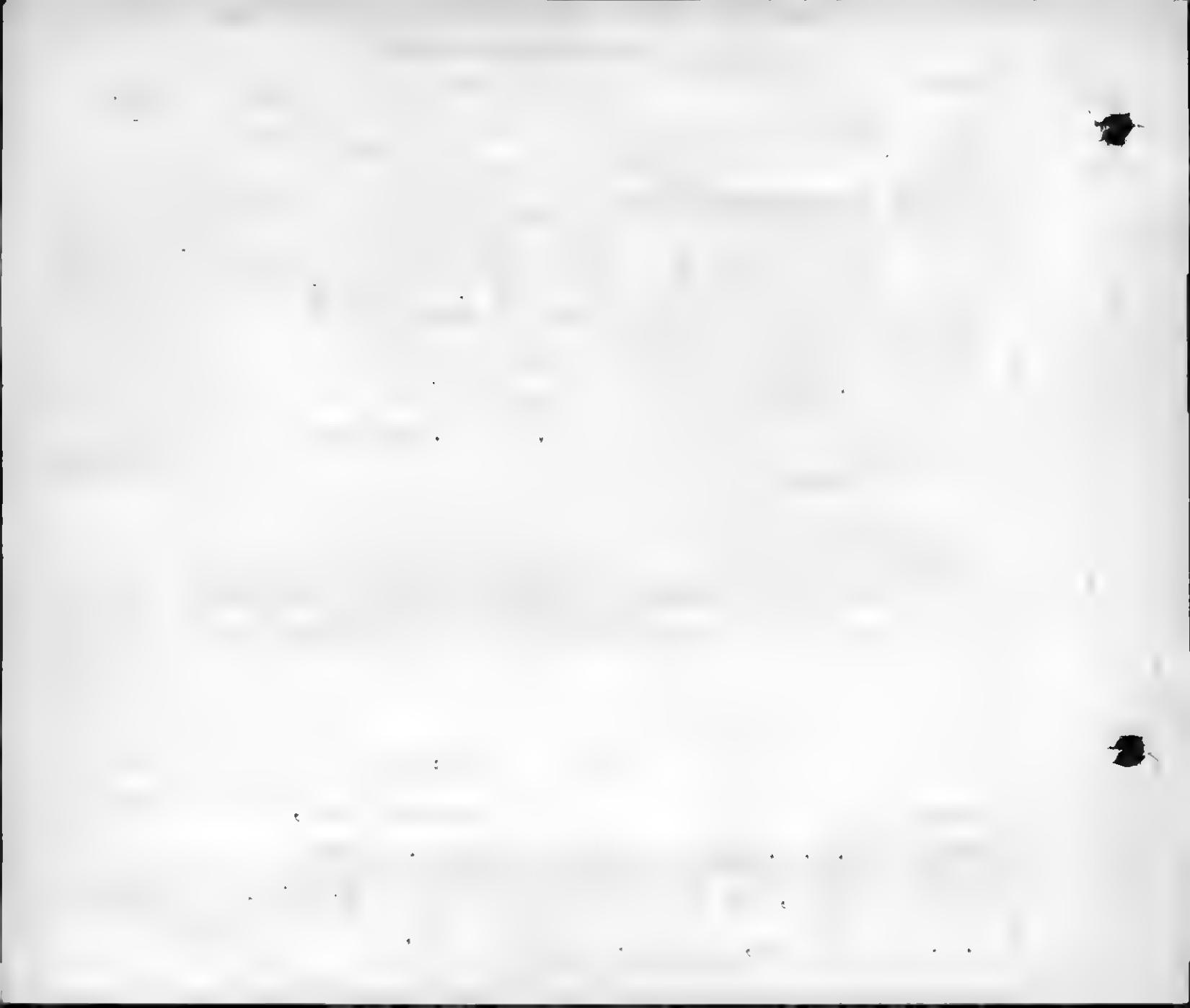
## CERTIFICATE OF DEATH

05712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>28 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>		d STREET ADDRESS <b>124 East Seventh Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>AGNES</b>	Last <b>SPURRIER</b>	4. DATE OF DEATH <b>May 19,</b>	Month <b>May</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1877</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Layman</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Poole</b>			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Roscoe C. Spurrier-Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myositis.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
402.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Astro. Sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. North Market Street, Frederick, Maryland		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE <b>H.F. Kline</b>				ADDRESS (Street, city or town, state) <b>M.D. North Market Street, Frederick, Maryland</b>		DATE SIGNED <b>5/21/1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>A. L. Seach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

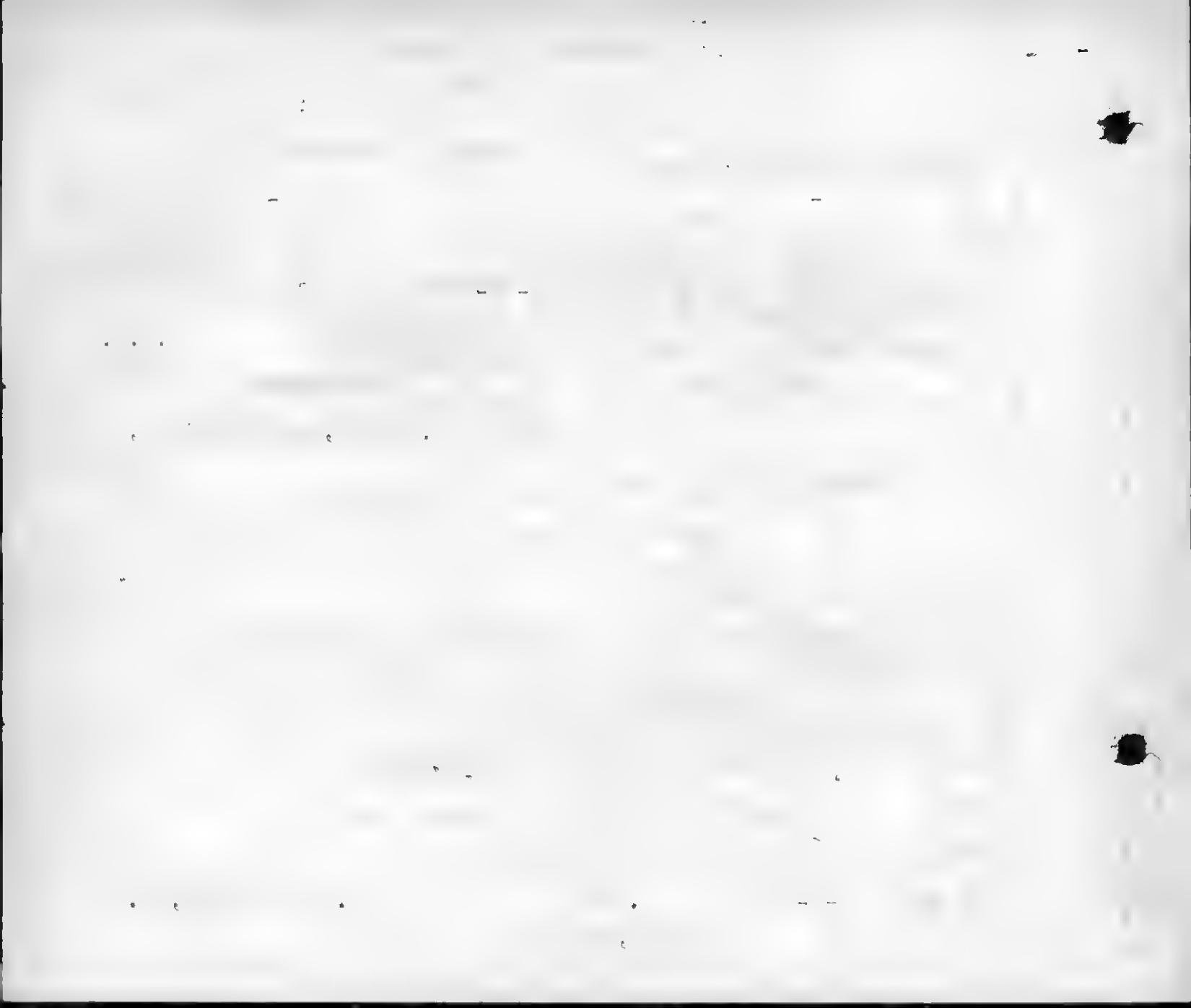
## 5731 CERTIFICATE OF DEATH

Reg. Dist. No.

05713

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Burkittsville)</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rurial Burkittsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Myrtle</b>		First <b>Ruch</b>	Middle <b>Staley</b>
4. DATE OF DEATH Month <b>5</b>		Day <b>1</b>	Year <b>1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1876</b>	
9. AGE (In years from birthday) <b>81</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Ruch</b>		14. MOTHER'S MAIDEN NAME <b>Mary Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>William T. Staley, Burkittsville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Medical history: anemia from intestinal bleeding - cause unknown.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1958</b> to <b>5-1-1958</b> , that I last saw the deceased alive on <b>4-30-1958</b> , and that death occurred at <b>12:55 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. E. Pruitt</b>		ADDRESS (Street, City or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>5-1-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-3-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Petersville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. LaFesta</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albermarle</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, 9 File No 02225-13-58 et

5698

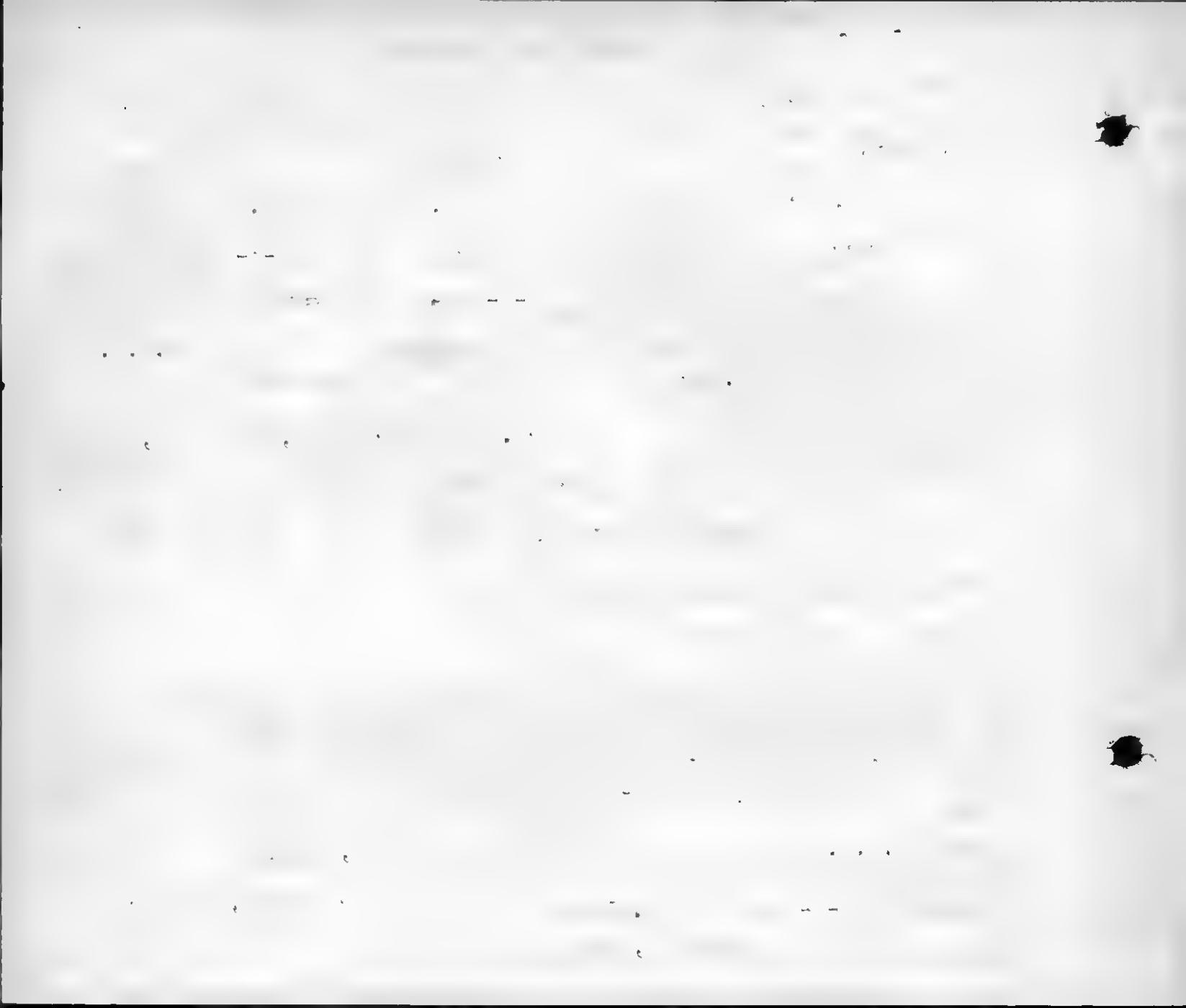
## CERTIFICATE OF DEATH

Reg. Dist. No.

05714

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 N. Virginia Avenue</b>		d. STREET ADDRESS <b>13 N. Virginia Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Carrie</b>	First <b>Carrie</b>	Middle <b>Mae</b>	Last <b>Stewart</b>
4. DATE OF DEATH <b>5-1-1958</b>	Month Day Year 19		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-1889</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jasper L. Dern</b>		14. MOTHER'S MAIDEN NAME <b>Alice Few</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. Address <b>Mrs. Ethel Strailman, Brunswick, Md</b>	
17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>2214</b> DUE TO <b>Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO <b>Arteriosclerosis</b>		<b>24 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/16/57</b> to <b>5/1/58</b> , that I last saw the deceased alive on <b>5/1/58</b> , and that death occurred at <b>Brunswick</b> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>K. G. F. Smith</b>		ADDRESS (Street, City or town, State) <b>M.D.</b> DATE SIGNED <b>5/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fife</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Debrauch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5691 CERTIFICATE OF DEATH

05715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL and give nearest town Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Route 5- Frederick</b>			
f. STREET ADDRESS <b>/</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b>	First <b>Sylvester</b>	Middle <b>Stine</b>	4. DATE OF DEATH <b>May 21st.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>Oct. 22-1882</b>		
9. AGE (In years lost birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>		
13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	14. FATHER'S NAME <b>Lawson P. Stine</b>	15. MOTHER'S MAIDEN NAME <b>Laura Routzahn</b>	16. ADDRESS		
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	18. SOCIAL SECURITY NO. <b>214-10-5926</b>	19. INFORMANT <b>Richard Williams- Ridge Rd.-BraddockHgts.-Md.</b>	20. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b></b>		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Professional Bldg.</b>	(County) <b>Frederick</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>5/21</b> , to <b>5/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/20</b> , 19 <b>58</b> , and that death occurred at <b>1:10A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>5-22-58</b>					
ACTUAL SIGNATURE <i>James B. Thomas</i>	PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>	M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 23-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick</b>	(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline &amp; Son</i>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR <b>Alfred J. Schuch</b>	24b. REGISTRAR'S SIGNATURE		
VS A1S (4) 15M 9/55	DATE <b>MAY 26 '58</b>				



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

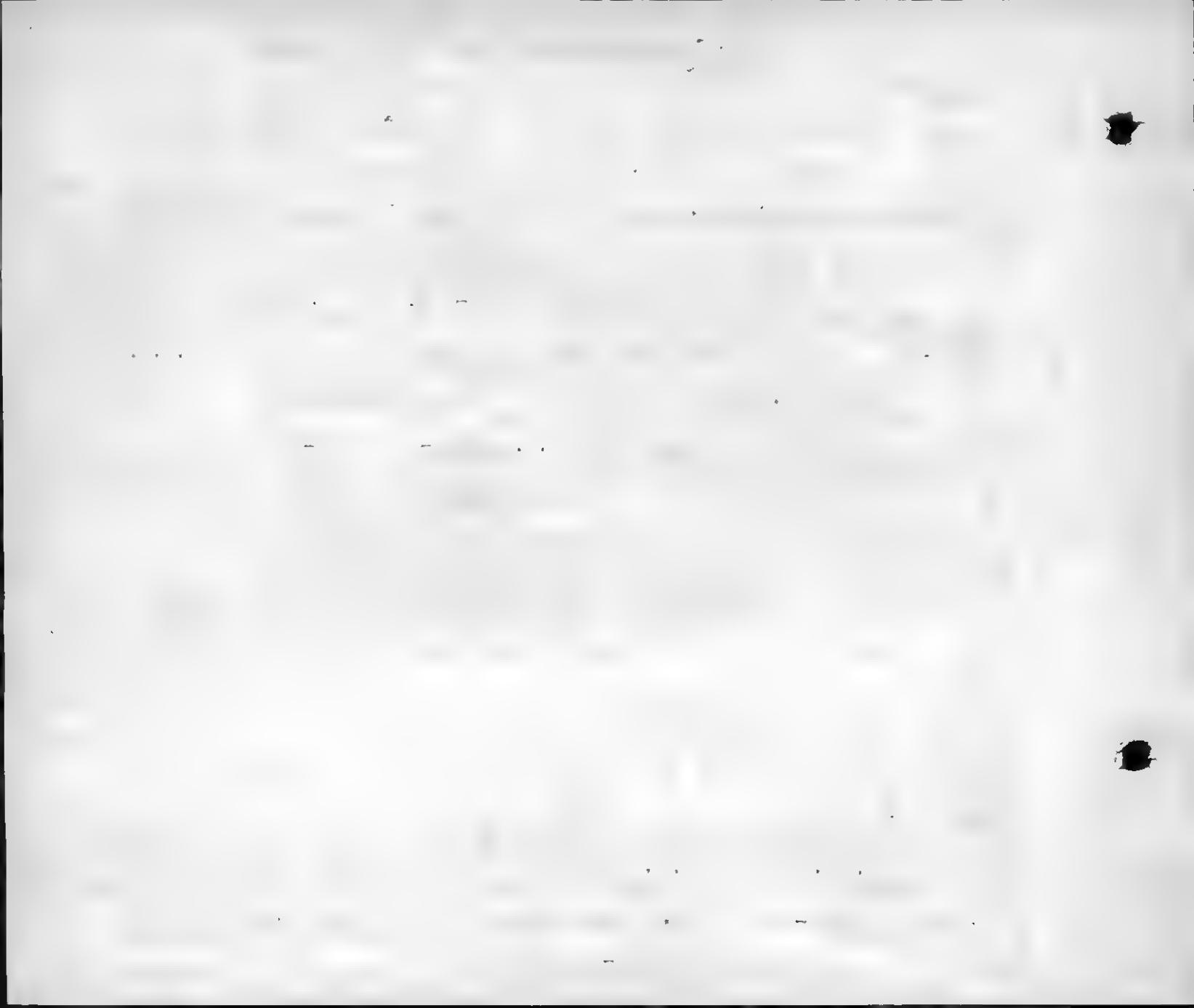
05716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5692		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick MARYLAND				a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		Lifetime		Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Enroute to Frederick Mem. Hospital		126 West Church Street			
3. NAME OF DECEASED (Type or print)	First George	Middle David	Last Stull	4. DATE OF DEATH	Month May Day 5 Year 1958
5. SEX	6. COLOR OR RACE	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED	8. DATE OF BIRTH	9. AGE (in years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
M	W		July 5-1890	yr.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machinist		Naval Gun Factory		Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Carlton L. Stull		Mary Margaret Kolb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes W War 1		None		A.B.Collmus-Frederick-Maryland	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH					
420.0 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)
Hour a. m. p. m.		19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE	<i>B. O. Thomas</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	B. O. Thomas, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	5/6/58
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
Burial	May 8-1958		Mt. Olivet Cemetery		Frederick Maryland
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
<i>C. E. Cline &amp; Son</i>	Frederick- Maryland		DATE MAY 7-58		<i>C. E. Cline &amp; Son</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5732 CERTIFICATE OF DEATH

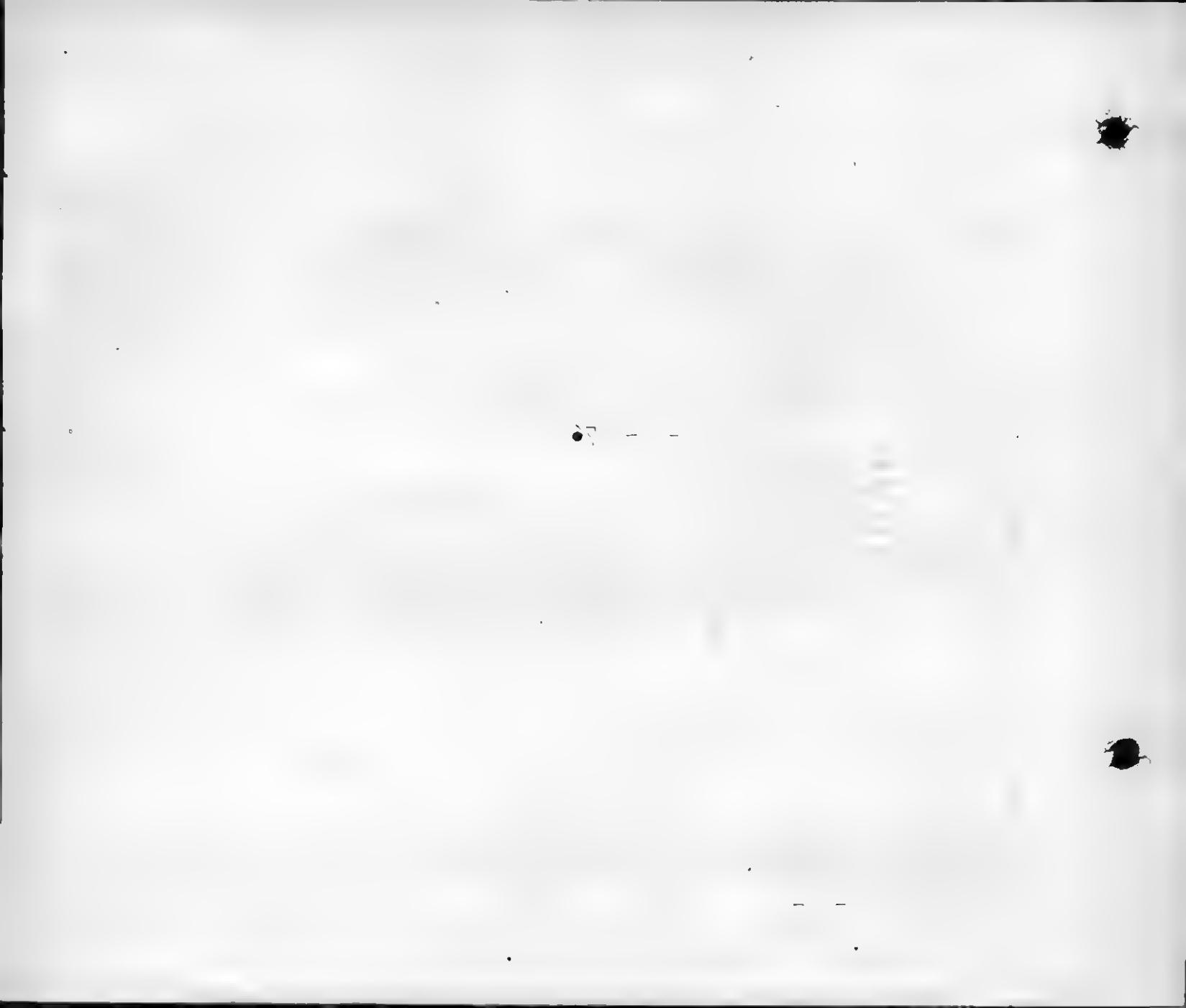
Reg. Dist. No.

05717

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Rural</b>		c. LENGTH OF STAY IN lb <b>75 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Thurmont RD 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Aaron</b>	Last <b>STULL</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>22</b>	Year <b>1958</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1876</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>82</b>	Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Stull</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Eigenbrode</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>219-20-0376</b>		17. INFORMANT <b>Mrs. Clara Schumaker</b>	Address <b>Thurmont, Md. RD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive vascular disease</b> DUE TO <b>731X</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO <b>3 days</b> (c) <b>Hypertension</b> DUE TO <b>7</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized myocardial ischemia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>ADDRESS (Street, city or town, state)</b>					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>May 22, 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Thurmont</b>	(County) <b>Frederick</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>May 22, 1958</b> , to <b>May 22, 1958</b> , that I last saw the deceased alive on <b>May 22, 1958</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DATE SIGNED</b> <b>M. Franklin Birley</b> M.D. <b>Thurmont, Md.</b> <b>5/23/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>5-25-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>United Brethren Cem.</b>	22d. LOCATION (City, town, or county) <b>Thurmont, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	24a. REC'D BY REGISTRAR <b>MAY 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Creager</b>		



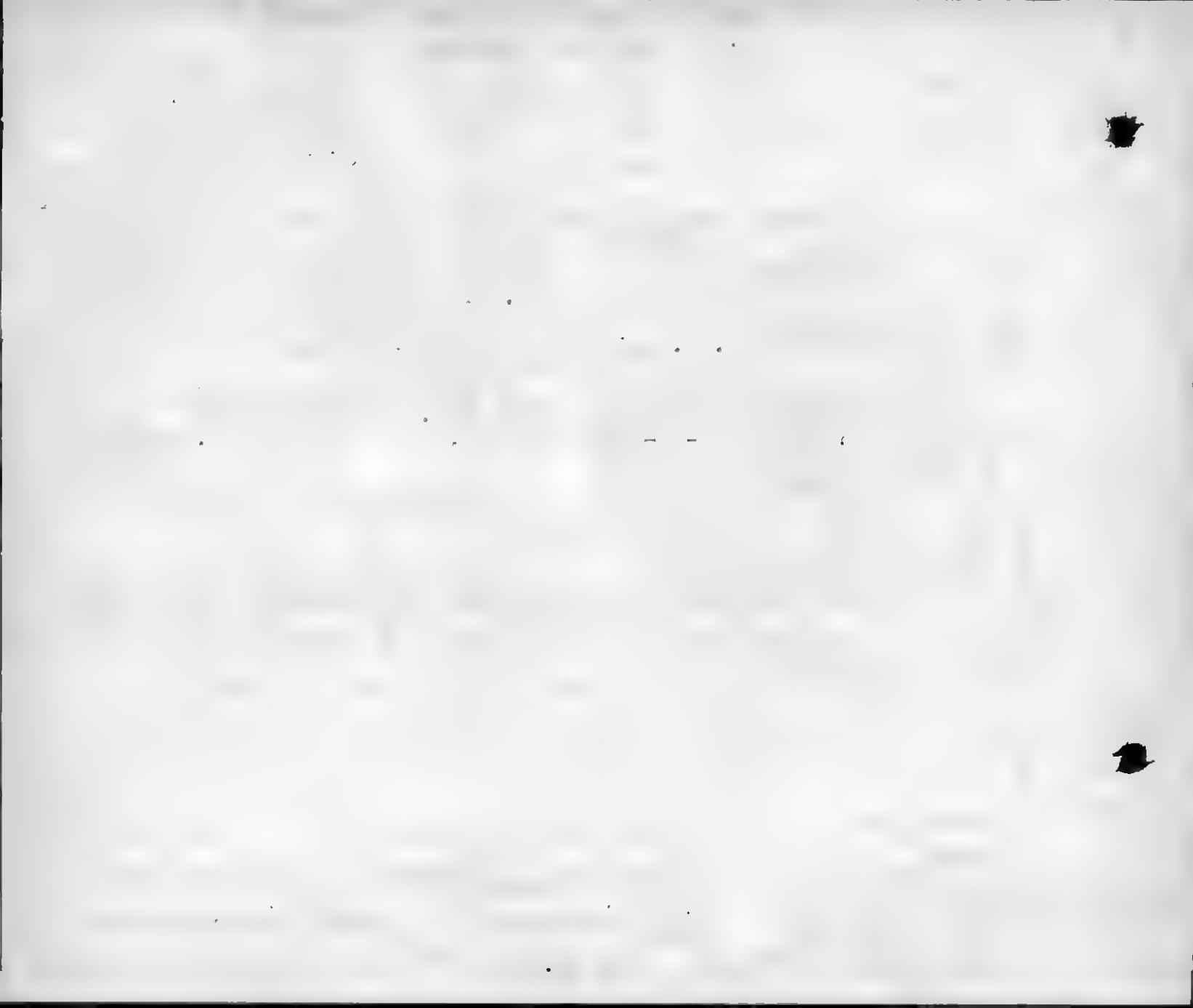
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5693 CERTIFICATE OF DEATH

Reg. Dist. No 05718

1. PLACE OF DEATH a. COUNTY		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Frederick</i>		<i>MARYLAND</i>	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	Maryland Washington	
<i>Frederick</i>		<i>2 days</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<i>Frederick Memorial Hospital</i>		Weverton Road		
3. NAME OF DECEASED (Type or print)	First	JOHN	TILGHMAN	THOMPSON
4. DATE OF DEATH	Month	Day	Year	
	May	31	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
<i>M</i>	<i>W</i>		<i>Nov. 25, 1905</i>	<i>52</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
<i>Car Inspector</i>		<i>B.&amp;O. Railroad</i>	<i>Weverton, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>USA</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
<i>John William Thompson</i>		<i>Martha Elizabeth Holder</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	
<i>No</i>		<i>705-10-3033</i>	<i>Mrs. Pearl Thompson Box 388, RFD #1, Knoxville, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute Coronary Thrombosis</i>		
4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>2 days</i>		
(b) DUE TO Arteriosclerotic Heart Disease		<i>2 years</i>		
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/27</i> , 1958, to <i>5/31</i> , 1958, that I last saw the deceased alive on <i>5/30</i> , 1958, and that death occurred at <i>5 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE	<i>Henry V Chase</i>			<i>5/31/58</i>
PHYSICIAN'S NAME (Type)	<i>Henry V. Chase</i>			<i>Frederick Maryland</i>
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>6/3/58</i>	<i>Brownsville Heights</i>	<i>Brownsville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 3 '58	24b. REGISTRAR'S SIGNATURE	
<i>Donald Ziebler</i>	<i>Harpers Ferry West Va.</i>		<i>A. L. Esch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should remain with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5733

## CERTIFICATE OF DEATH

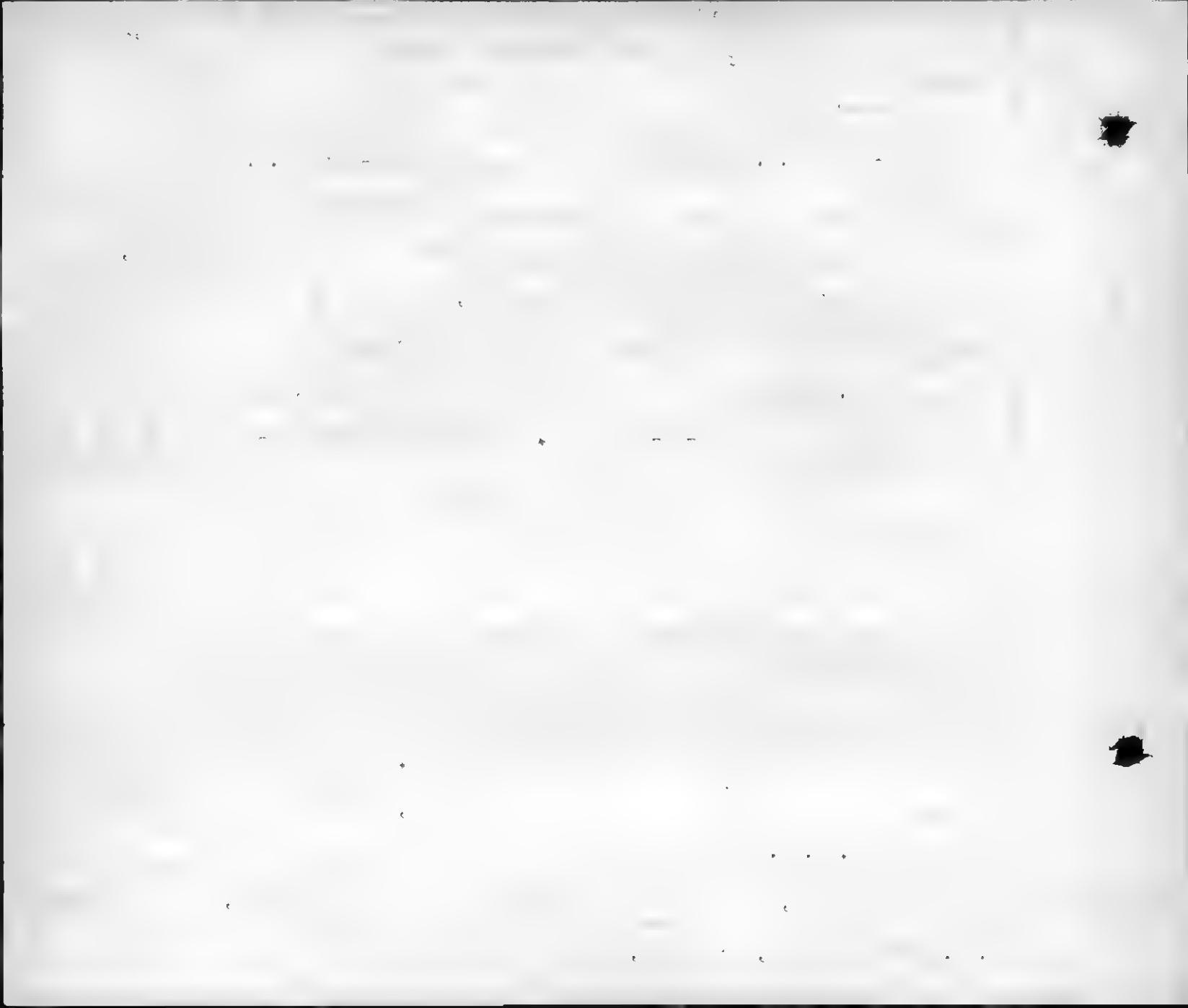
Reg. Dist. No.

05719

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural-R.D.#1</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural-R.D.#1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lander Road</b>		d. STREET ADDRESS <b>Lander Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NELLIE</b>		First <b>VIRGINIA</b>		Middle <b>THRASHER</b>		4. DATE OF DEATH <b>May 24, 1958</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1895</b>	9. AGE (In years lost birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cephus E. Lekin</b>				14. MOTHER'S MAIDEN NAME <b>Flora B. Souder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or date of service) <b>214-36-2496</b>		17. INFORMANT <b>Mr. George Edward Thrasher-Same as Item #1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4 heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Hypertension P/V Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arthritis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 24, 1958</b> , to <b>May 27, 1958</b> , that I last saw the deceased alive on <b>May 24, 1958</b> , and that death occurred at <b>7:00P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b>							
DATE SIGNED <b>5/26/58</b>							
ACTUAL SIGNATURE <b>A. T. Brice</b>							
PHYSICIAN'S NAME (Type) <b>Dr. A. T. Brice</b>		22d. LOCATION (City, town, or county) <b>Jefferson, Maryland</b>					
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>May 27, 1958</b>		22g. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>D. Etchison</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and immediately filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05720

## 5694 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>236 A North Market Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ANN</b>	Middle <b>ELIZABETH</b>	Last <b>TINNEY</b>	4. DATE OF DEATH <b>May 25, 1958</b>	Month <b>May</b>	Day <b>25</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>March 28, 1887</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR yrs. <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin F. Shelton</b>			14. MOTHER'S MAIDEN NAME <b>Anna Biser</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9794</b>		17. INFORMANT <b>Mrs. Charles H. Thomas, Frederick R.D., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23, 1958</b> to <b>May 25, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>9:50 A.M.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>5/26/58</b>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>							
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b> <b>Frederick, Maryland</b>							
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS DATE <b>MAY 27 '58</b>			
24a REC'D BY REGISTRAR				24b REGISTRAR'S SIGNATURE <i>C. L. Etchison</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05721

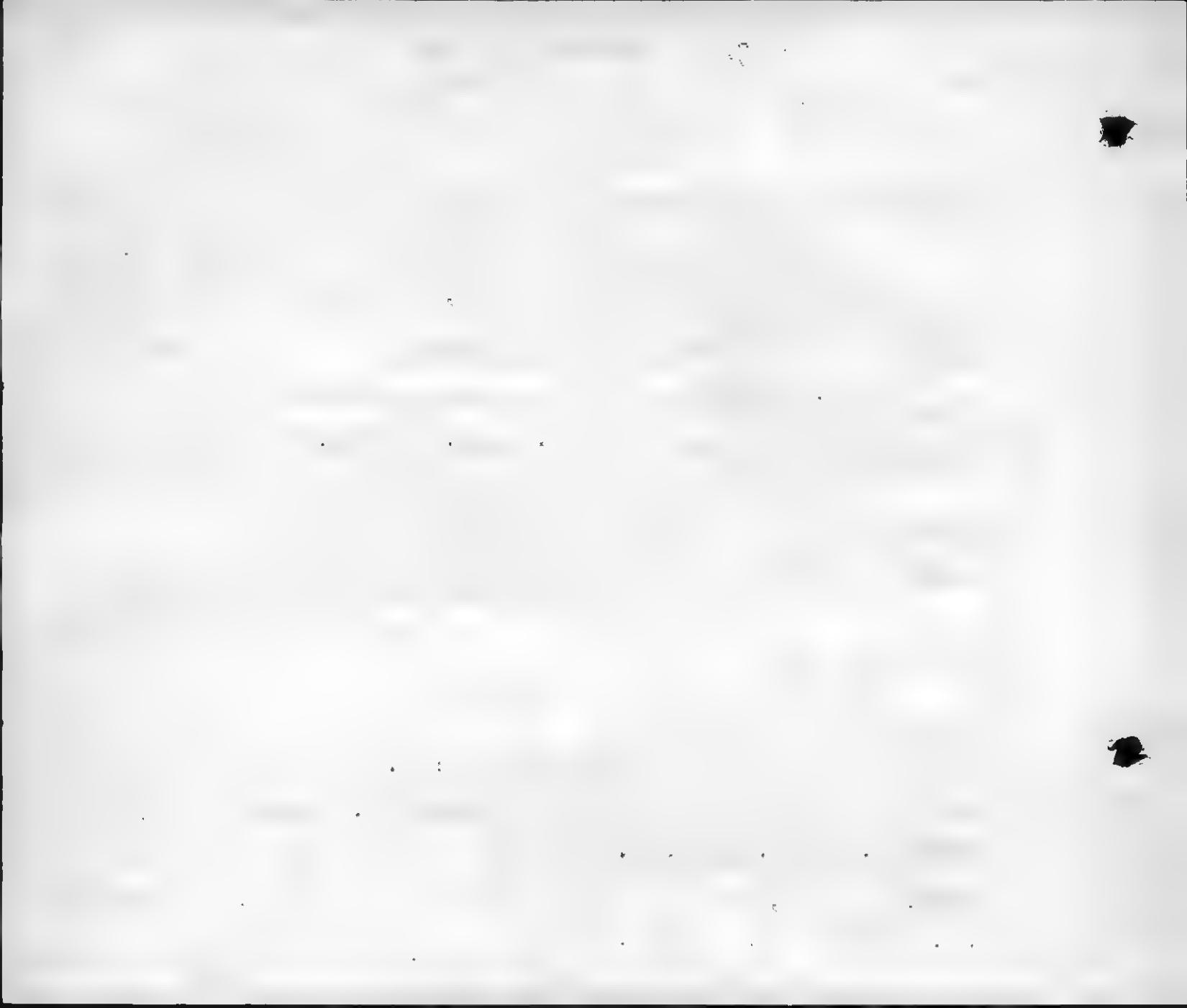
## 5695 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				d. STREET ADDRESS <b>110 West 13th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SARAH</b>	Middle <b>ROSEANA</b>	Last <b>UTTERBACK</b>	4. DATE OF DEATH <b>May 21, 1958</b>	Month <b>May</b>	Day <b>21</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1889</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Haberkorn</b>				14. MOTHER'S MAIDEN NAME <b>Emmeline Schuffler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N. ne</b>		17. INFORMANT <b>Mr. Gary L. Utterback, Same as item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension vera</i> INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bangrene left foot.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>19 May 1958</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Walkersville, Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Aug 1957</b> to <b>21 May 1958</b> , that I last saw the deceased alive on <b>20 May 1958</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walkersville, Maryland</b> DATE SIGNED <b>5/23/58</b>							
ACTUAL SIGNATURE <i>James E. Stoner, Jr.</i>							
PHYSICIAN'S NAME (Type) <b>Dr. James E. Stoner, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>	
						24b. REGISTRAR'S SIGNATURE <i>W. J. Etchison</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached from the certificate and given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5696

## CERTIFICATE OF DEATH

05722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>FREDERICK</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		d. STREET ADDRESS <i>64 Taney Apts.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address)* OR INSTITUTION <i>Frederick Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>L</i>	Middle <i>O</i>	Last <i>W</i>	4. DATE OF DEATH <i>MAY 9, 1958</i>	Month <i>MAY</i>	Day <i>9</i>	Year <i>1958</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 13, 1882</i>		9. AGE (In years, last birthday) <i>76 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Burned Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick County, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Jacob H. Wachter</i>		14. MOTHER'S MAIDEN NAME <i>Annie Roberts.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-10-81254</i>		17. INFORMANT <i>Mary C. Wantz.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Diabetic Acidosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>?</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>UREMIA + INFECTION (URINARY)</i>						
DUE TO (c)		<i>Benign Prostatic Hypertrophy</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>May 9, 1958</i> , to <i>May 2, 1958</i> , that I last saw the deceased alive on <i>May 9, 1958</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Robert D. Crouch</i>		M.D.		<i>101 Frederick Shopping Ctr 5/9/58</i>		DATE SIGNED <i>5/9/58</i>		
PHYSICIAN'S NAME (Type) <i>ROBERT D. CROUCH</i>				<i>Frederick, Maryland</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 13, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Utica and Reformed</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Co. Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Hailey</i>		ADDRESS <i>1201 N. Market Frederick</i>		24a. REC'D BY REGISTRAR <i>M.</i> DATE <i>MAY 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. Crouch</i>		

1970

1970

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5697

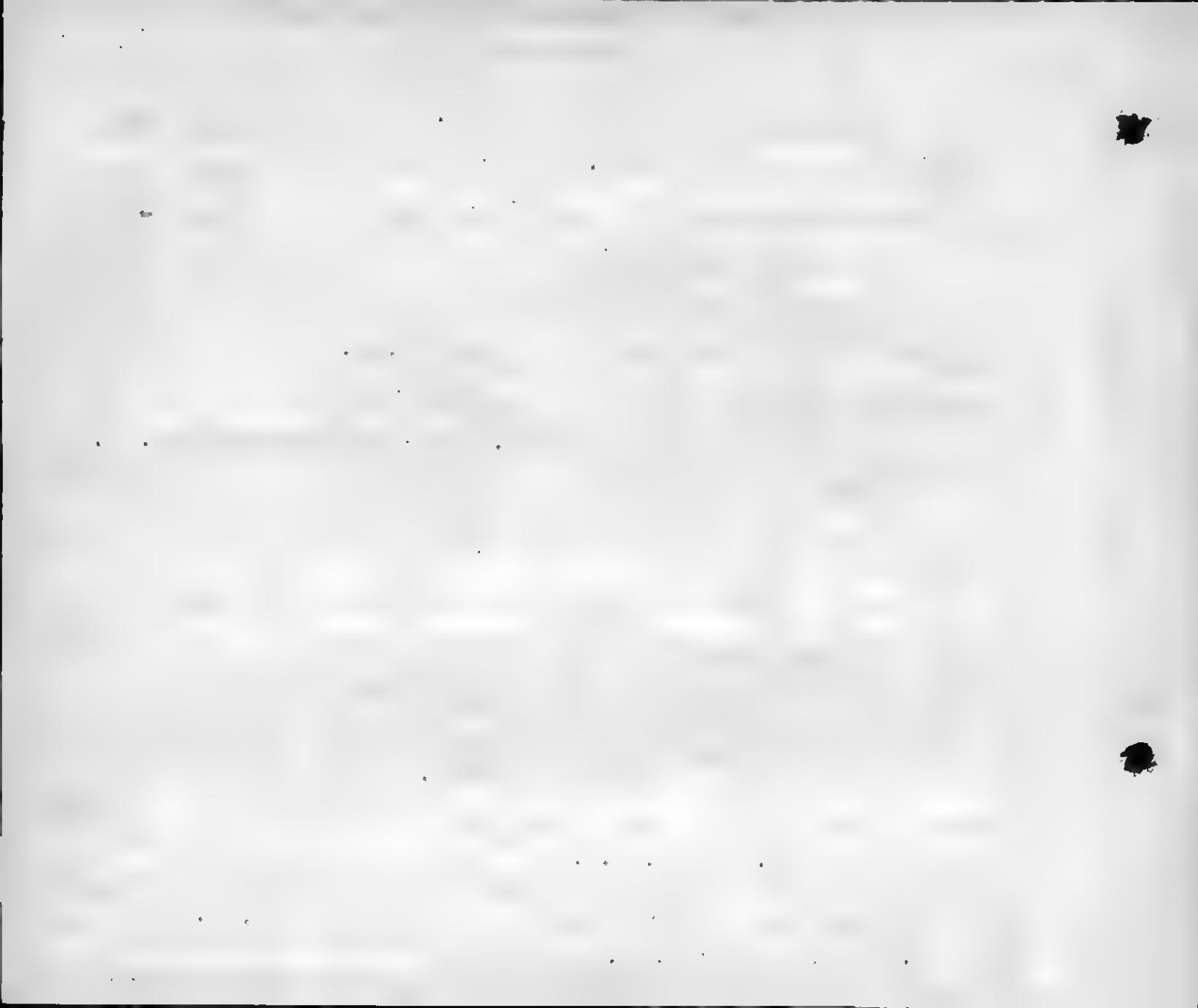
## CERTIFICATE OF DEATH

Reg. Dist. No.

05723

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. If institution: Residence before admission  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in and attached with carbon paper. Then please remove carbon paper. Pages 1 and 2 should be filled in and attached with carbon paper.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>60 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>111 Ice Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 Ice Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nancy Elizabeth Baton Williams</b>		First	Middle	Last	4. DATE OF DEATH <b>May 13</b>	Month	Day	Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 9-1875</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Henry Baton</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Green</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ruth G. Dixon -- 111 Ice Street Fred. Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH Hours		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440.0</b>		<b>Acute pulmonary edema</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		<b>Arteriosclerotic heart disease</b>					Years		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Frederick</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from _____, 1956, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 8: P. M., from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>228 N. Market Street</b>		
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D. <b>James B. Thomas, M.D.</b>					DATE SIGNED <b>5/14/58</b>		
PHYSICIAN'S NAME (Type) <b>James B. Thomas</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 16-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks 111 Frederick, Md.</b>		ADDRESS <b>111 Frederick, Md.</b>		24a. REGISTERED BY REGISTRAR <b>MAY 16 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hicks</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5734

## CERTIFICATE OF DEATH

Reg. Dist. No.

05724

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Lewistown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Lewistown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 1 Thurmont</b>				d. STREET ADDRESS <b>Rt. 1 Thurmont</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Eli.</b>	Middle <b>Armenius</b>	Last <b>Wolfe</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>14</b>	Year <b>19 58</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6-1883</b>	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fish Hatchery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fish Hatchery Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Lewistown-Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Calvin A. Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Anne Ricketts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mae Ambush Wolfe--Thurmont Rt. 1 Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>May 10</b> , 19 <b>58</b> , to <b>May 14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 13</b> , 19 <b>58</b> , and that death occurred at <b>3: A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dr. B.O. Thomas Jr.</b> ADDRESS (Street, city or town, state) <b>228 N. MARKET STREET</b> DATE SIGNED <b>May 19 1958</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 17-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview</b>	22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 19 1958</b>	24b. REGISTRAR'S SIGNATURE <b>John C. Conner</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5735

## CERTIFICATE OF DEATH

Reg. Dist. No.

05725

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the Hospital or attending physician.**

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>29 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>Bill Moxley Rd.</b>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WALTER</b>	First	Middle	Last
4. DATE OF DEATH <b>MAY 13</b>	Month	Day	Year 19 58
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James E. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Vinnie R. Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I 215-09-1020</b>	
17. INFORMANT <b>Mrs. Helen E. Wright, Same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<b>Coronary Heart Disease</b> 18 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		<b>Acute Pulmonary Oedema</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25, 1956</b> , to <b>May 13, 1958</b> , that I last saw the deceased alive on <b>May 6, 1958</b> , and that death occurred at <b>10:52 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. J. Slusher</i>		ADDRESS (Street, city or town, state) <b>9 E. Church St. Frederick, Md.</b> DATE SIGNED <b>5/14/58</b>	
PHYSICIAN'S NAME (Type) <b>H. J. SLUSER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-16-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Marvin Chapel</b>		22d. LOCATION (City, town, or county) <b>Frederick Co., Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alv. couch</b>	

ST-3300M/T/L-R2A-10 REV 07/16/1992 STATE: 001A0720